CHAPTER 9:

Billing on the UB Claim Form

Reviewed/Revised: 10/1/2018

9.0 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. This chapter covers paper claim submission only, for additional information on electronic claim submission, please see Chapter 7 section 7.4.

- 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 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.
- Steward Health Choice Arizona does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied
- ICD-10-PCS 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.

General

The pay to and practice addresses on the claim form must match the information in the Steward Health Choice Arizona claims payment system. Your Provider Performance 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. Steward Health Choice Arizona reserves the right to request additional documentation to support the claim.

<u>All pertinent records for the following:</u>

- Prior Period Coverage inpatient admissions- Except routine newborn and Maternity
- Psychiatric Services
- Outlier Claims
- Level 4 APR-DRG claims
- Level 4 and 5 Emergency Department Claims

- Out of State Claims
- Authorization on file does not match services being billed

9.1 COMPLETING THE UB CLAIM FORM

The UB form is used to bill all hospital inpatient, outpatient, emergency room, and hospital based clinic charges. Dialysis clinics, skilled nursing facilities, freestanding birthing centers and hospice facility charges are also billed on the UB.

Listed below are the *required* field numbers. Each field number corresponds with the field numbers shown on the UB-04 claim form (attachment). 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 Rendering Provider (see #1).

3a. Patient Control No. **Required if Applicable**

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

3b. Medical Record No. **Required if Applicable**

4. Bill Type **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See *AHA Uniform Billing Manual* for codes.

2.	3a. PATIENT CONTROL NO.	4. TYPE OF BILL
	b. MED REC NO.	**111**

5. FedTax No. **Required**

Enter the facility's federal tax identification number.

5. FED TAX NO.	6. STATEMENT COVERS	PERIOD	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 thru 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
	02/15/2003	**02/20/2003**	

7. Reserved **Not required**

8. (a–b) Patient Name/Identifier **Required**

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

9. (a-e) 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. The hospital enters the date the patient was admitted for inpatient care (MMDDYY)

13. Admission Hour (HR) **Required if applicable**

14. Priority (Type) of Visit/Admission **Required**

Required for all claims. Enter the code that best describes the members' 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**

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

16. Discharge Hour **Required if applicable**

Required for inpatient claims when the recipient has been discharged.

17. Patient Discharge Status **Required**

This code indicates the patient's discharge status as of the "Through" date of the 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 intermediate care (IFC)
05	Discharge/Transferred to a designated cancer center or children's hospital
06	Discharge/Transferred to home under care of 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**

A code(s) used to identify conditions or events relating to this bill. To bill for multiple distinct/independent outpatient visits on the same day facilities must enter "G0".

29. Accident State **Required if applicable**

30. Reserved **Not Required**

Not currently used.

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

Occurrence codes and associated dates define a significant event relating to this bill that may affect processing.

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

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

37. Reserved (Not currently used) **Not Required**

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. These fields are required for Medicare part A and B and for Dialysis patients:

A1 Use for Medicare Part A deductible
A2 Use for Medicare Part B coinsurance
A3 Benefits Exhausted
B1 Use for Medicare part B deductible
B2 Use for Medicare Part B coinsurance
C1 Third Party Payer deductible
C2 Third Party Payer coinsurance
49 Hematocrit test results
68 EPO units administered A8 Patient weight A9 Patient height.

42. Revenue Codes **Required**

Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. 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.

Revenue Code categories are four digits.

42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	45. SERV. DATE
013			
025			
025			

43. Revenue Description/NDC **Required**

The standard abbreviated description of the related revenue code categories included on the bill in Field 42. The description should correspond with the Revenue Codes as defined by the NUBC.

42. REV. CD.	**43. DESCRIPTION**	44. HCPCS/RATES	46. SERV. UNITS
	OB/3&4 BED		
	DRUGS/GENERIC		
	IV SOLUTIONS		

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.

Providers must 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.
- 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 codes and modifiers when billing for outpatient services.

42. REV. CD.	43. DESCRIPTION	**44. HCPCS/RATES**	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. CD.		43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	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 17) and statement covers period (Field 6). If the recipient has been discharged, Steward Health Choice Arizona 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, Steward Health Choice Arizona covers the admission date through last date billed.

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

42. REV. CD.		43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	**2.00**

47. Total Charges **Required**

Total charges pertaining to the related revenue code (Field 42) 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 0001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.

Note – 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 on the final page. Use Rev Code 0001 for the total charges. Multi-page claims should have this field left blank. The total charges should *only be entered on the last page of a multi-page claim.*

48. Non-covered Charges **Required if applicable**

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

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

49. Reserved (Currently not used) **Not Required**

50. (A-C) Payer Name **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 Steward Health Choice Arizona, Steward Health Choice Arizona should be the last entry. If there are no payers other than Steward Health Choice Arizona, Steward Health Choice Arizona will be the only entry.

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

Entered the facility's ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. This is a number used by the health plan to identify itself.

52. (A-C) Release of Information Certification Indicator **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. (A-C) Assignment of Benefits Certification Indicator **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.

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

A unique identification number assigned to the provider submitting the bill by the health plan. Enter AHCCCS # for atypical providers.

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

The name of the individual under whose name the insurance benefit is carried as listed in Field 50.

59. (A-C) Patient's Relationship to Insured **Not required**
Code indicating the relationship of the patient to the identified insured.

60. (A-C) Insured's Unique Identifier (HCG/AHCCCS ID #) **Required**
Enter the recipients Health Choice Arizona ID number as reflected on the members ID card. The unique number assigned to the health plan to the insured.

61. (A-C) Insured's Group Name **Not required (per AHCCCS)**
The group or plan name through which the insurance is provided to the insured.

62. (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. AHCCCS does not require.

63. (A-C) Treatment Authorization Code **Not required**
A number or other indicator that designates that the treatment indicated on this bill has been authorized by the payor. You may include the Health Choice Arizona Prior Authorization Number. If there is a Prior Authorization approved within the Health Choice Arizona Claims system, the claim will validate the presence of the Authorization during processing.

64. (A-C) Document Control Number (DCN) **Not required**
A control # assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. **If the claim is a replacement or void, the original CRN shall be entered in this field.**

65. (A-C) Employer Name (of the Insured) **Not required (per AHCCCS)**
The name of the employer that provides health care coverage for the insured individual.

66. Diagnosis and Procedure Code Qualifier (ICD) **Not required**
The qualifier that denotes the version of International Classification of Diseases (ICD) reported.

68. Principal diagnosis code and Present On Admission (POA) indicator **Required**
Enter the principal diagnosis code and present on admission indicator. Present on Admission (POA) Indicator is required by AHCCCS. The principal diagnosis is the condition established after study to be chiefly responsible for the admission.

69. (A–Q) Other Diagnosis Codes and Present On Admission (POA) indicator
Enter other diagnosis codes and present on admission indicators Present on Admission (POA) Indicator is required by AHCCCS.
Behavioral Health providers must NOT use DSM-4 diagnosis codes.

70. Reserved **Not required**

71. Admitting Diagnosis **Required**

Required for **inpatient claims**. Enter the ICD10 diagnosis code that describes the patient's diagnosis at the time of the admission.

72. (a–c) Patient's Reason for Visit **Required if applicable**

73. Prospective Payment System (PPS) Code **Required if applicable**

AHCCCS does not require this filed to be populated.

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

Enter ECI diagnosis codes when applicable. All inpatient claims require a POA indicator.

73. Reserved (Currently not used) **Not Required**

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

Enter the Principal ICD procedure code and the corresponding date on which the principal procedure was performed during the inpatient stay or outpatient visit. 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.

74. (a-e) Other Procedure Codes and Dates **Required if applicable**

75. Reserved (Currently not used) **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. Enter the Claims Reference Number (CRN) assigned to the original bill by Steward Health Choice Arizona. **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. (a-d) - Code – Code Field **Required if applicable**

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