UB-04 Billing Instructions

Updated October 2016

The UB-04 is a claim form that is utilized for Hospital Services and select residential services. Please note that these instructions are specifically written to correlate with Partners Behavioral Health Management's Claim Management System – Alpha MCS. This guide gives detailed line by line instructions on how to complete the UB-04 claim form. Paper Formatted UB-04s should have all relevant information completed manually prior to claims submission to Partners. All Direct Entry (Provider Portal) and paper formatted UB-04 claims should follow the instructions that follow in this guide.

Provider Types
The following Provider types should bill using the UB-04 claim form:
- Hospitals
- Intermediate Care Facilities for Individuals with Intellectual Disabilities(ICF/IID)
- Psychiatric Residential Treatment Facilities(PRTF)
- Residential Treatment Facilities Level II-IV
- Therapeutic Leave for *all* Residential Services and including Level II Family Type(Therapeutic Foster Care)

Web Portal – Alpha MCS
Providers are encouraged to utilize the Partners Behavioral Health Management Web Portal for claims entry through the Alpha MCS Software. This portal is available 24 hours a day and seven days a week. This provides rapid, efficient information exchange between providers and Partners. The portal can be accessed at:

https://login.alphamcs.com/alphamcs/AlphaMCS.aspx#/Views/PortalLogin.xaml

Paper Claims
It is the goal of Partners' Claims Department to ensure that all providers are able to submit billing timely and not be a barrier during transitional times. For that reason paper Claims will be accepted during transition times on a limited basis.

Claims should be completed accurately to ensure proper claim adjudication.
- Paper Claims should be completed on an original UB-04 claim form
- No photocopied claims will be accepted
- Use Blue or Black Ink only
- Information should be legible on the form
- Do not use highlighters
- Do not use correction fluid or correction tape
- Ensure that names, codes, numbers, etc. print in the designated fields for proper alignment if printing forms
- Claims must be signed. Rubber signatures are acceptable for claims filing.

Multi-Page Paper Claims
If submitting UB-04's with multiple pages, please follow these guidelines:
- Multi-page claims are **limited to 2 pages** with a maximum of **44 claim lines**
- Do not total on the first page
- Staple or clip the 2 pages together, but do not staple more than once
- Indicate **page X of 2** in **line 23** of **Field 42**
- Total charges must be located at the bottom of **Field 42** on the **second page**
- If reporting a TPL(third party liability) payment, indicate in field 54 on the first page
- One copy of an attachment (EOB, EOMB, Consent forms, etc.) is required per claim when applicable
- All attachments should be clearly marked with the beneficiary's name and Medicaid ID

Paper Claims should be mailed to:

Partners Behavioral Health Management
Attn: Claims Management Department
901 S. New Hope Road
Gastonia, NC 28054-5829

Electronic (Web Portal) Submissions of UB-04 Claims

This section gives instruction on how to navigate and utilize the UB-04 Claims Module within the Partners' Alpha MCS Web Portal.
To navigate to the UB-04 claims entry module within the Alpha MCS system:

Login to the Alpha MCS Web Portal. On the Menu button, choose Claims:

To create a NEW UB-04 Claim Click on "Create". To find a previous Claim that is in progress or for using the "copy" or "view" function, click on "Filter" and increase level of detail by clicking on "3". You can utilize the copy function to create exact duplicates of previous claims in order to submit ongoing billing with minimum changes to the claim or to submit replacement or to void(revert) claims in the Partners claims system
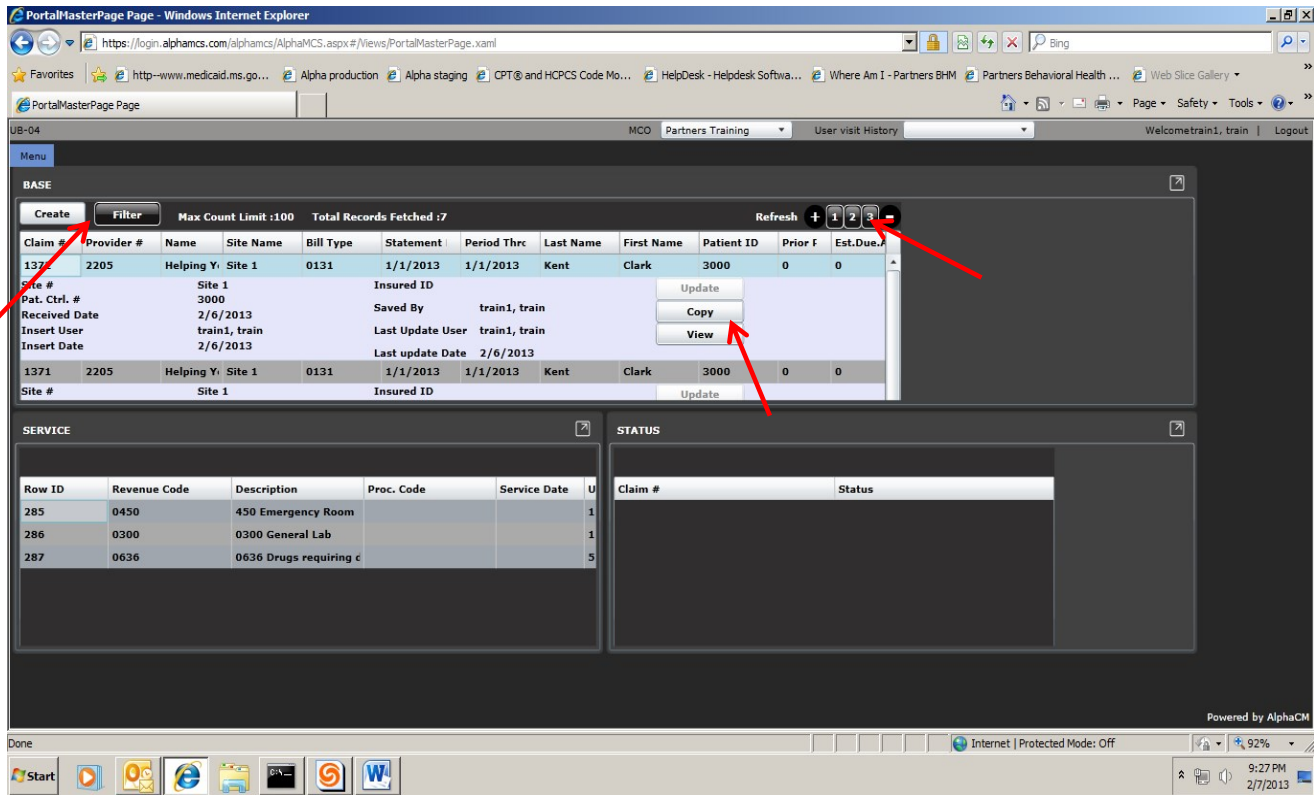
When you click "filter" you may search for a previous saved or submitted claim. You will utilize a search filter to find any claim you have previously created. Note that this is not going to show you payment or denial information. This is just the physical formatting of the claim that you have created.
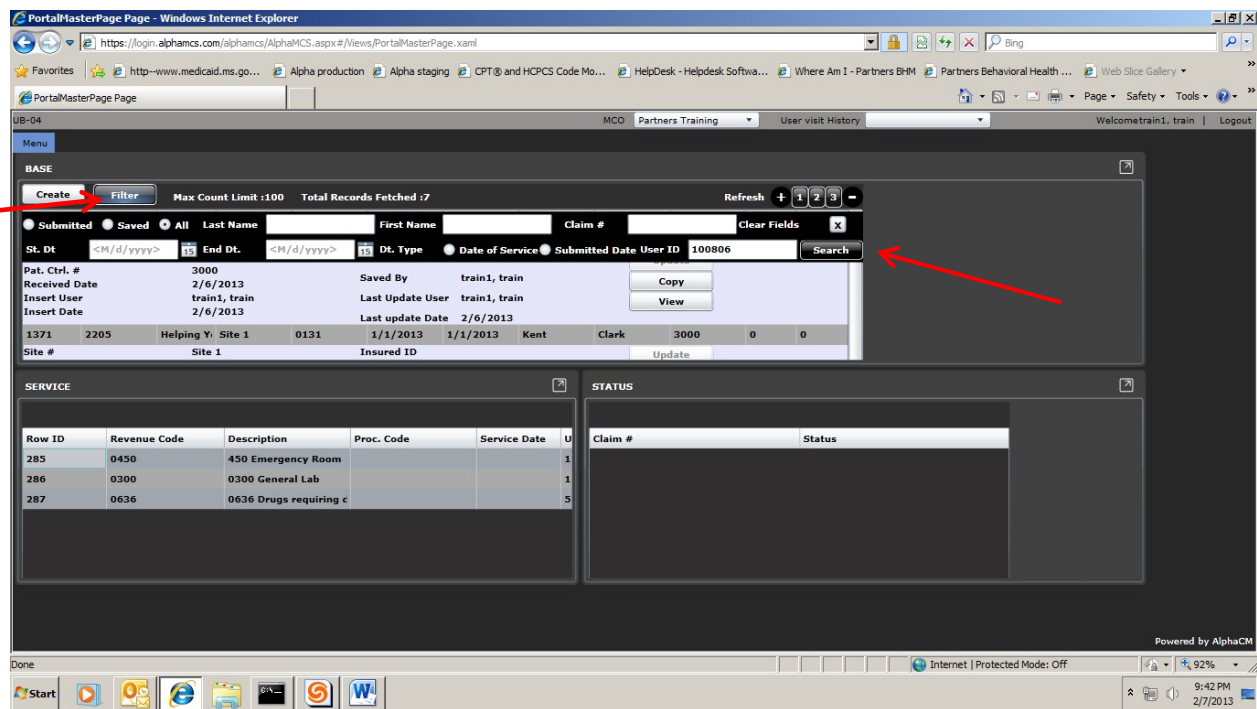
After you click on "create" you will be able to create a new UB-04 claim. The next section will provide detailed instructions and descriptions on the UB-04 Form. Please also see the attachments at the end of this guide for quick instructional tools that can also be utilized as a reference guide and tool for the UB-04.

This section will give a detailed view of "box by box" view to help guide through the UB-04 claim form.

Box 1 – Billing Provider Site Information: (Required) This information should be auto-populated from the Claims Management System. Paper formatted claim should have this information entered prior to submission of claim. You will need to choose the site you are billing for if more than one is available for choice in the drop down box.

Box 2 – Pay to Provider: (Not required) Only utilize if submitting a paper formatted UB04. This box does not show up on the Alpha MCS UB-04 claim form.

Box 3a – Patient Control Number: (Optional) This number will be auto-populated when a patient is entered through the search feature in box 8. Paper formatted claim should have the Provider record number if known.

Box 3b – Medical Record Number: (Optional)This number will be auto-populated from the Claims Management System once box 8 is completed. Paper formatted claim should have the Partners BHM record number if known.

Box 4 – Bill Type: (Required)The Type of bill code is comprised of three parts; a leading "0", the Facility Type Code, and the Bill Frequency Type Code. This field should be 4 digits when completed. The first two digits following the zero indicate the type of facility. The final digit indicates the type of bill. Below are all acceptable codes to bill to Partners:

Inpatient Hospital Claims
0111 – Hospital Inpatient – Admit through Discharge
0112 – Hospital Inpatient – First Claim
0113 – Hospital Inpatient – Continuing Claim
0114 – Hospital Inpatient – Last Claim
0117 – Hospital Inpatient – Replacement Claim
0118 – Hospital Inpatient – Void Claim

Hospital Outpatient (Including Emergency Department)
0131 – Hospital Outpatient (including ED) – Admit through Discharge
0137 – Hospital Outpatient (including ED) – Replacement Claim
0138 – Hospital Outpatient (including ED) – Void Claim

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
0651 – Intermediate Care – Admit through Discharge
0652 – Intermediate Care – First Claim

0653 – Intermediate Care – Continuing Claim
0654 – Intermediate Care – Last Claim
0657 – Intermediate Care – Replacement Claim
0658 – Intermediate Care – Void Claim

Psychiatric Residential Treatment Facilities (PRTF)
0891 – Residential – Admit through Discharge
0892 – Residential – First Claim
0893 – Residential – Continuing Claim
0894 – Residential – Last Claim
0897 – Residential – Replacement Claim
0898 – Residential – Void Claim

The Alpha MCS system is designed to treat each claim that is submitted as a "whole" claim. You can submit Bill types ending in 1 if the claim includes "all" dates of service including the date of discharge. This would include claims such as Hospital Outpatient or Inpatient Hospital. If you submit Interim bills, the "first claim" should be submitted with a bill type that ends in a "2". Continuing interim claims should be submitted with a bill type that ends in a "3". Interim Bills that are submitted for dates of service that include the date of discharge should be submitted with a bill type that ends with a "4".

Box 5 – Federal Tax ID Number: (Not required) This is auto-populated from the Claims Management System. Paper formatted claims should have this information manually entered.

Box 6 – Statement Period From and Through Dates: (Required) Enter the eight digit beginning service date in the "From" box and the eight digit ending service date in the "Through" box. Dates are to be entered in the "mm/dd/yyyy" format. *Note if the claim submitted has a discharge date– the date of discharge is not billable for payment.

Box 7 – Reserved for local use. Do not submit information in this box.

Boxes 8-11 – This patient information is auto-populated from the Claims Management system when utilizing the patient search feature. Paper formatted claims should have this information entered exactly as it appears on the Recipients Medicaid Identification Card.

Box 12 – Admission Date: (Required) Enter the eight digit date of admission. Dates are to be entered in the "mm/dd/yyyy" format.

Box 13 – Admission Hour: (Required if applicable) Enter the physical time of admission if applicable – required for Hospital claims.

Box 14 – Admission Type (priority) of Visit: (Required) This field requires a one digit code that indicates the priority of the admission.

1 – Emergency
2 – Urgent

3 – Elective
5 – Trauma Center

Box 15 – <u>Source of Referral for Admission:</u> (Required if applicable) Indicate the source using the one digit code that represents the source of referral for admission. Required on Hospital claims.

1 – Physician Referral
2 – Clinic Referral
3 – HMO Referral
4 – Transfer from a Hospital(different facility)
5 – Transfer from a Skilled Nursing Facility
6 – Transfer from Another Heath Care Facility
7 – Emergency Room
8 – Court/Law Enforcement

Box 16 – <u>Discharge Hour(DHR):</u> (Required if applicable)This field requires two digit(military time) codes to indicate the discharge hour. Required on Hospital claims

Box 17 – <u>Patient Discharge Status:</u> (Required if applicable) This field indicates the discharge status of the patient when service is ended/complete. This field is a 2 digit code.

01 – Discharged to home or self-care (routine discharge)
02 – Discharged/transferred to another short-term general hospital for inpatient care 03 – Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care.
04 – Discharged/transferred to a facility that provides custodial or supportive care
05 – 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.
07 – Left against medical advice or discontinued care.
09 – Admitted as an inpatient to this hospital
 Note: Only applies to services that began great than three days prior to admission or that were unrelated to the reason for admission.
20 – Expired (or did not recover – religious non-medical health care patient)
21 – Discharges/transferred to court/law enforcement
30 – Still patient or expected to return for outpatient services
43 – Discharged/transferred to a Federal Health Care facility
50 – Discharged/transferred to hospice – home(inpatient only)
51 – Discharged/transferred to hospice – medical facility(inpatient only)
61 – Discharged/transferred within this institution to a hospital based Medicare approved swing bed.
62 – Discharged/transferred to an inpatient rehab facility, including distinct part units of a Hospital
63 – Discharged/transferred to a 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 – Discharged/transferred to another type of health care institution not defined elsewhere in the code list

Box 18-28 – Condition Codes : Not required unless applicable for the service.

Box 29-Accident State: Not Required.

Box 31-34, a-b – Occurrence Codes: Not required unless applicable for the service

Box 35-36 –Occurrence Span codes and dates: Not required

Box 38 – Insured Name and Address: (Required) This information will auto-populate from the Partners BHM Claim Management System

Box 39-41; a-d – Value codes and amounts: (Optional) Use these locators to indicate codes and amounts essential to the proper adjudication of the submitted claim. Each form locator contains a three digit field in which to key the indicator code, and a larger free text field in which to designate an applicable amount.

   Patient Responsibility – Key "31" in the code box of this field to identify the value code as patient liability. Key the amount of patient minimal liability due in the Amt. box.

   Covered Days – Key "80" in the code box and the number of covered days in the amount.

   Non-Covered Days – Key "81" for the code and the number of non-covered days as the amount.

   Share of Cost – Key "23" to show a payment that is a share of cost.

Box 42 – Revenue Code: (Required) For General Hospitals, please use the appropriate revenue code(s) in a 4 digit format with a leading zero. Ex. 0100 not 100. Only claims with appropriate diagnostic ranges of 290-319 will be paid.

   Inpatient Hospital/Residential/ICF: Paid on a state negotiated per diem all inclusive basis
   Codes: 0100, 0101,0113,0114,0116,0120,0123,0124

   Emergency Department: Paid at 80% of the Medicaid approved RCC: Codes: 0450-0459(labs are paid at 100%)

Note for ED services, Revenue Codes for ancillaries may be billed in addition to the ED charge. RC 0253 and RC 0636 for take home medications are non-covered services.

Hospital Outpatient Claims:
Codes: 0901,0903,0905,0906,0907,0912,0913,0914,0915,0916,0918,0919

Intermediate Care Facilities Claims (ICF/IID):
Code: 0100

Psychiatric Residential Treatment Facility:
Code: 0911

Long term Residential:
Code: 0902 (H0019)(H2020)

Therapeutic Leave
Code: 0183

Box 43 – Description: (Required) This will be auto-populated based upon choice of Revenue Code

Box 44 – HCPCS/HIPPS Code: (Required if applicable)This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a PPS(prospective payment system)

For all other types of facilities:
When billing Therapeutic leave for the following residential services:
        *H0019
        *S5145
        *H2020
Use the HCPCS Code indicated on the authorization letter for Therapeutic Leave.

ICF/IID – Does not require a HCPCS code be entered for Therapeutic Leave

Box 45 – Service Date: (Required if applicable) Indicates the date the outpatient service was provided and the date the bill was created using the following format (mm/dd/yyyy)

Note: if billing for a span of dates that include Therapeutic Leave, you will need to bill a separate claim for the residential charges prior to the dates of TL, the dates of TL, and a claim for the residential dates following the TL dates.

Otherwise, enter the individual eight digit service date for each line item billed. Dates are to be entered in the "mm/dd/yyyy" format.

Box 46 – Service Units: (Required) Enter the number of units, days, or visit, where appropriate

Box 47 – Total Charges: (Required) For General Hospitals enter the charges for the total number of charges billed for each service indicated. Otherwise, enter the rate for the charge being billed.

Box 48 – Non-Covered Charges: (Required if applicable) Enter the charge for any non-covered services such as take home drugs.

Box 50-55 – Other Payer /Coordination of Benefits Information: Enter the appropriate information if applicable as follows:

> Box 50a-c: (Required) Primary Payer Name (Secondary/Tertiary information can be entered on the lines below.
> Box 51a-c: (Not required) Health Plan ID should be entered into this box to identify the Health Plan
> Box 52a-c: (Not required) Each payer line will have a separate Assignment of Benefits Marker Box.
> Box 53a-c: (Not required) Each Payer line will have a separate Assignment of Benefits Marker Box.
> Box 54a-c: (Optional) Prior Payments – secondary payer: enter any prior payment amounts received toward payment of the bill for the payer indicated in box 50. Box 55a-c: (Not required) Estimated Amount Due: Enter estimated amount due from each indicated payer in box 50.

Box 56 – NPI – (Required) This is the Billing Providers NPI

Box 57 – (Not required)

Box 58 a-c– Insured Name-(Required)Enter the name of the policyholder for the primary/secondary/tertiary health plan as indicated in Box 50a-c

Box 59a-c – Patient Relationship: (Required) Identify the relationship of the patient to the primary insurance policyholder using the following two digit codes:

> 01 – Spouse
> 18 – Self
> 19 – Child
> 20 – Employee
> 21 – Unknown
> 53 – Life Partner
> G8 – Other Relationship

> **Note – This is the relationship of the patient to the policy holder, so if the patient's parents are the policy holders, the subsequent relationship would be "19 – Child"

Box 60a-c – Insured ID Number: (Required) Enter the number assigned by the primary health plan to identify the specific policy of the insured.

Box 61a-c – Group Name: (Only required when patient has other insurance coverage)

Box 62a-c – Insured Group Number: (Only required when patient has other insurance coverage)

Box 63a-c – Treatment Auth Codes: (Not required)

Box 64A – Document Control Number: If the bill type indicates a replacement or voided claim, enter the Partners BHM Claim Header ID of the original submitted claim in this field. You will find the claim number on your Remittance Advice.

Box 65a-c – Employer Name: (Not required)

Box 66 – Principal Diagnosis Code: (Required) Enter the Primary ICD-10 Diagnosis Code in this box marked with an asterisk.

Box 67 – (additional diagnosis fields) Secondary Diagnosis Codes: (Optional) Enter secondary diagnosis code(s) as applicable

Box 69 – Admitting Diagnosis Code (Inpatient/Residential Claims only): Enter the diagnosis code describing the patient's diagnosis at the time of admission

Box 70 – 72: (Not required)

Box 74a-e – Principal Procedure Codes (Optional and only for Hospital claims)

Box 76 – Attending NPI: (Required if applicable) (Clinician/Physician/Agency) that actually delivered the service.

Box 77-79 – (Not required)

Box 80 – Remarks Field: (Not required) Can be used to put free text for remarks or comments

Box 81CCa – Taxonomy Code: (Required) Enter your taxonomy code in box 81CCa of the UB-04. The value B3 will be hard coded into the first field. This identified the value to be entered as the Provider's Taxonomy Code. Enter the taxonomy code in the box to the right of where "B3" is located.

Once you have completed all required fields, you can choose to save or submit your claim. If all fields are accurate and complete, you may choose to submit your claim. If you still have items that need addressing and you do not want to submit yet but rather want to "save" so that you can work on later, you may choose to Save.

Attachment: Checklist of Required UB-04 Fields

UB-04 Checklist for Required Fields	Required	Required if applicable	Optional or Not Required
1. Provider Name	✓		
2. Pay to Name			✓
3a. Patient Control Number			✓
3b. Medical Record Number			✓
4. Type of Bill	✓		
5. Fed. Tax Id			✓
6. Statement Covers period	✓		
7. Reserved for future use			✓
8-11. Patient information	✓		
12. Admission date	✓		
13. Admission hour		✓	
14. Admission Type	✓		
15. Source of Referral		✓	
16. Discharge Hour		✓	
17. Discharge Status		✓	
18-28. Condition codes		✓	
29. Accident State			✓
30. Reserved for Assignment			✓
31-34. Occurrence Codes			✓
35-36. Occurrence Span and dates			✓
37. Reserved for Assignment			✓
38. Responsible Party	✓		
39-41. Value Codes			✓
42. Revenue Code(s)	✓		
43. Revenue Code(s) description	✓		
44. HCPCS/rates/HIPPS Codes		✓	
45. Service Date		✓	
46. Units of service	✓		
47. Total Charges	✓		
48. Non-Covered Charges		✓	

UB-04 Checklist for Required Fields	Required	Required if applicable	Optional or Not Required
49. Reserved for Assignment			✓
50a-c Payer Name	✓		
51a-c Health Plan ID			✓
52a-c Release of Information		✓	
53a-c Assignment of benefits		✓	
54a-c Prior Payments		✓	
55a-c Estimated amount due			✓
56. Billing NPI	✓		
57a-c. Other Provider ID			✓
58a-c. Insured's Name	✓		
59a-c. Patient's relationship to insured	✓		
60a-c. Unique ID	✓		
61a-c. Group Name		✓	
62a-c. Insurance Group No.		✓	
63. Treatment Auth code			✓
64. Document Control Number		✓	
65a-c. Employer Name			✓
66. Diagnosis Version qualifier	✓		
67. Principal diagnosis Code			✓
67a-q. Other Diagnosis Codes			✓
68. Reserved for Assignment			✓
69. Admitting Diagnosis		✓	
70-73.			✓
74a-e. Principal Procedure Codes			✓
75. reserved for assignment			✓
76. Attending Provider NPI	✓		
77. Operating Physician Info			✓
78-79. Other Provider Info			✓
80. Remarks			✓

81.acc. Taxonomy code	✓		