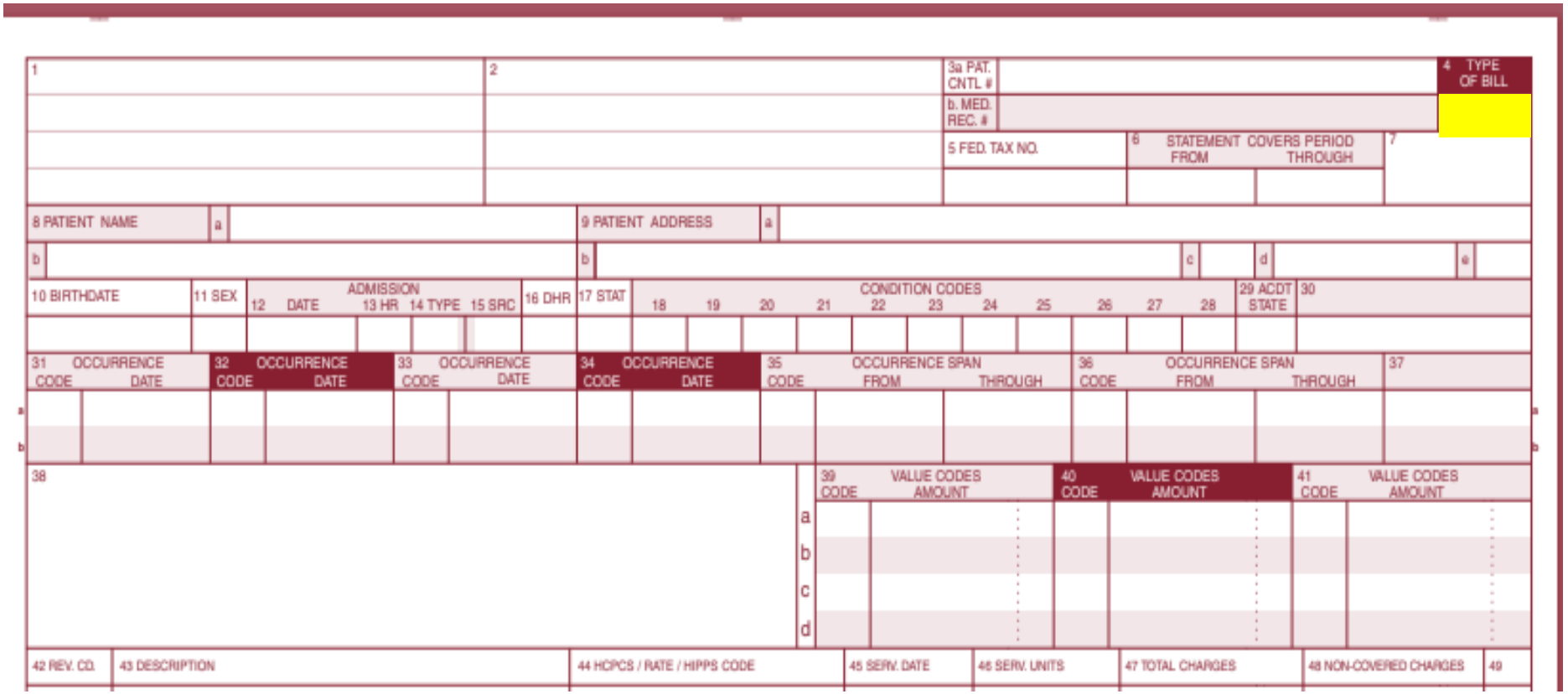
UB04 Claim Form

Optum MD Provider Education Series

Key Learning Points

- Field 4: Type of Bill (IP/OP)
- Field 6: Statement Covers Period (IP/OP)
- Field 15: Source of Referral
- Field 17: Patient Status
- Field 31-34: Occurrence Codes
- Field 39-41: Value Codes and Amounts
- Field 74: Other Procedure Codes & Dates
- Q & A

UB04 Form – Field 4: Type of Bill



Provider Types – Type of Bill

- **PT01**: Acute Hospitals
- **PT06**: Specialty/Other Acute Hospitals
- **PT07**: Specialty/Other Chronic Hospitals
- **PT55**: Intermediate Care Facility for Addictions
- **PT88**: Residential Treatment Centers (RTC)

Field 4: Type of Bill - Inpatient

- A 3 digit code indicating the specific type of bill
- Digit 3 indicates the sequence for episode of care – “frequency code”
- All 3 digits are required

Allowable Inpatient Bill Types (first 2 digits):

- 11x,15x, 21x, 65x, 86x

Interim Bill Types (digit 3):

- Frequency code
  - ‘1’ first/last claim for listed services
  - ‘2’ first claim
  - ‘3’ continuing claim
  - ‘4’ last claim
  - ‘7’ corrected claim

Common Denial Reason:

“Bill type is not compatible with provider type”

Provider Type/Bill Type Rules:

- **PT01:** Must be bill type ‘11x’
- **PT06:** Must be bill type ’11x’
  PT07: Must be bill type ‘15x’
- **PT55:** Must be bill type ‘65x
- **PT88:** Must be bill type ’86x

Field 4: Type of Bill - Outpatient

- A 3 digit code indicating the specific type of bill
- Digit 3 indicates the sequence for episode of care – “frequency code”
- All 3 digits are required

Allowable Outpatient Bill Type (first 2 digits):

- 13x

Allowable Outpatient Bill Types (digit 3):

- Frequency code
  - ‘1’ first/last claim for listed services
  - ‘7’ corrected claim

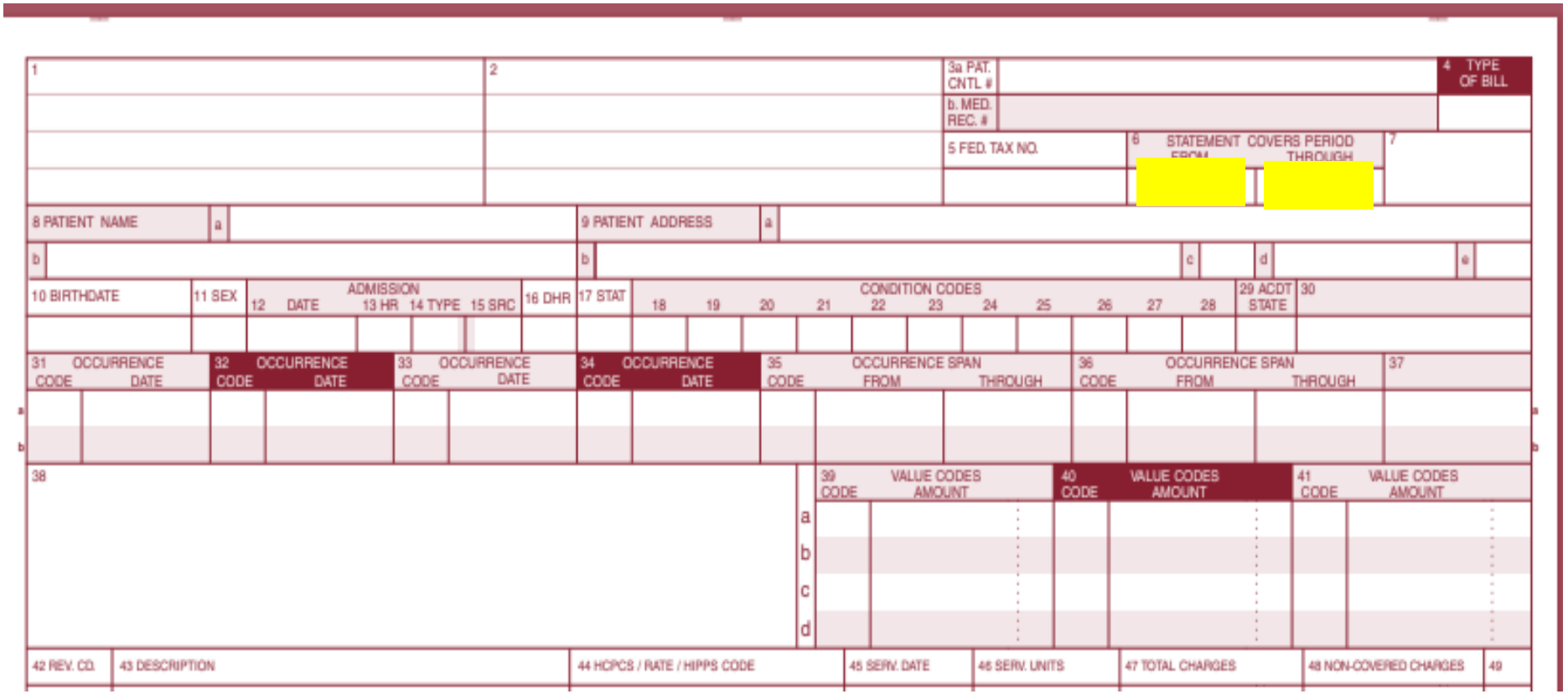
Common Denial Reasons:

“Invalid Bill Type”
Interim bill types for outpatient claims are not allowed

“Claim detail lines cannot span dates”
Outpatient bill types cannot have date spans

The only bill types allowed for Outpatient claims are:
131, 137 (PT01, PT06, PT07)

UB04 Form – Field 6: Statement Covers Period



Field 6: Statement Covers Period Inpatient

Inpatient Rules

- From and Through dates covered by service on invoice.
- Through date equals the date through which we are paying for accommodations.
- Death/discharge should never be shown as the Through date.
- Modifiers not allowed
- HCPCs or CPT codes not required
- Multiple like revenue codes are not allowed
  (example: 0300 unit of 1 listed twice, 0300 unit of 1 should be combined into one line of 0300 unit of 2).
- For IP claims, only 0450 is allowed. Codes 0451 & 0452 are combined into 0450 and only 0450 is billed.

Common Denial Reason

"Discharge date must be outside of statement covered period"

Discharge date must not be part of the statement covered period for In-Patient claims

Field 6: Statement Covers Period Outpatient

Outpatient Rules

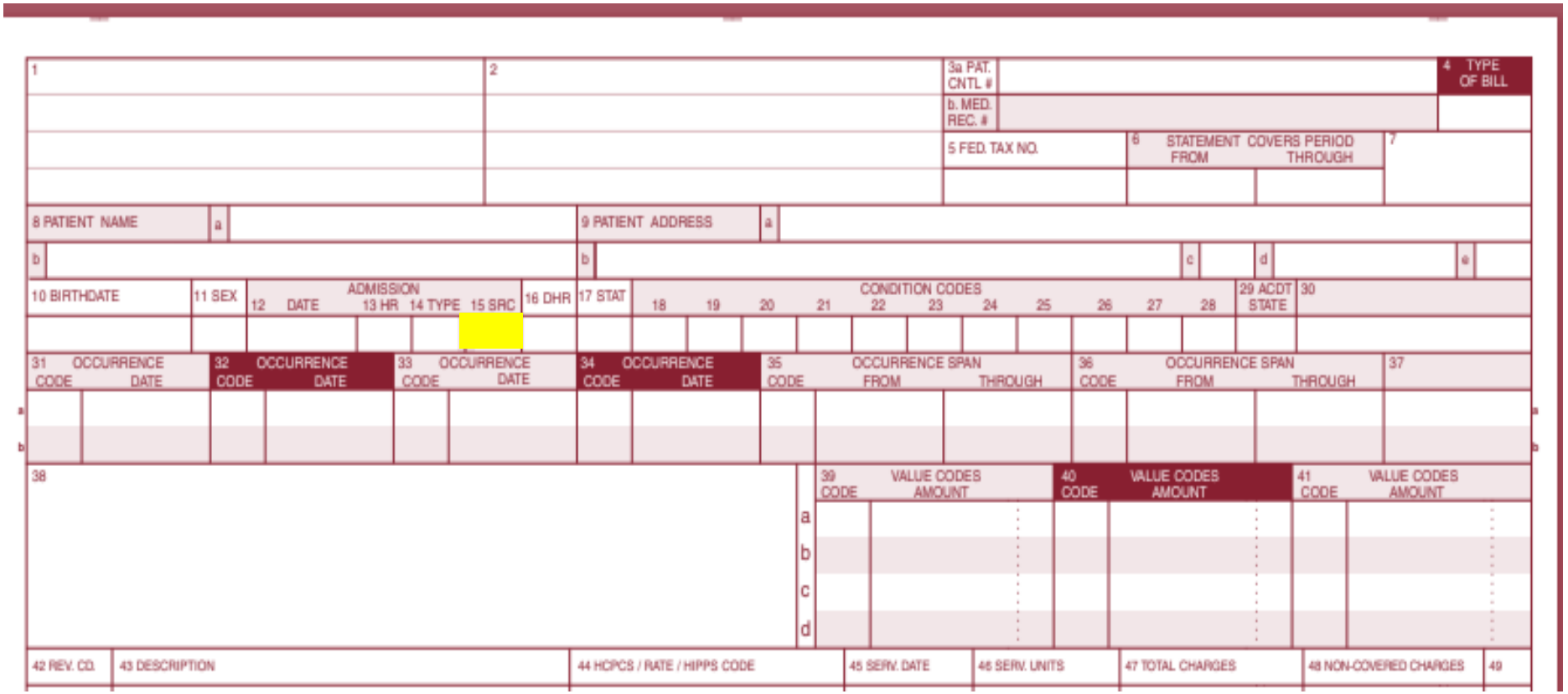
- Single day of services – From and Through dates will be the same
- Only one Date of Service (DOS) for outpatient charges may be billed on a single UB-04. Continuing treatment must be billed on a day-to-day basis.
- Emergency room visits: From and Through dates should be the day participant entered the ER, even if the visit extends past midnight.
- Outpatient Observation billing: separate outpatient claim for each day in an observation bed.
- Modifiers not allowed
- HCPCs or CPT codes not required
- Multiple like revenue codes are not allowed
  (example: 0300 unit of 1 listed twice , 0300 unit of 1 should be combined into one line of 0300 unit of 2).

Common Denial Reason

"Claim detail lines cannot span dates"

Outpatient bill types cannot have date spans

UB04 Form – Field 15: Source of Referral



Field 15: Source of Referral for Admission or Visit

- Applies to inpatient claims (optional for outpatient)
- Valid Values 1-9

Possible Field Values:

- 1: Physician Referral
- 2: Clinical Referral
- 3: HMO Referral
- 4: Transfer from a hospital
- 5: Transfer from a skilled nursing facility
- 6: Transfer from another health care facility
- 7: Emergency Room
- 8: Court/Law enforcement
- 9: Information not available (IP only)

Common Denial Reason:

"Invalid/missing admission source code"

This denial will appear on Inpatient claims if value is missing or invalid

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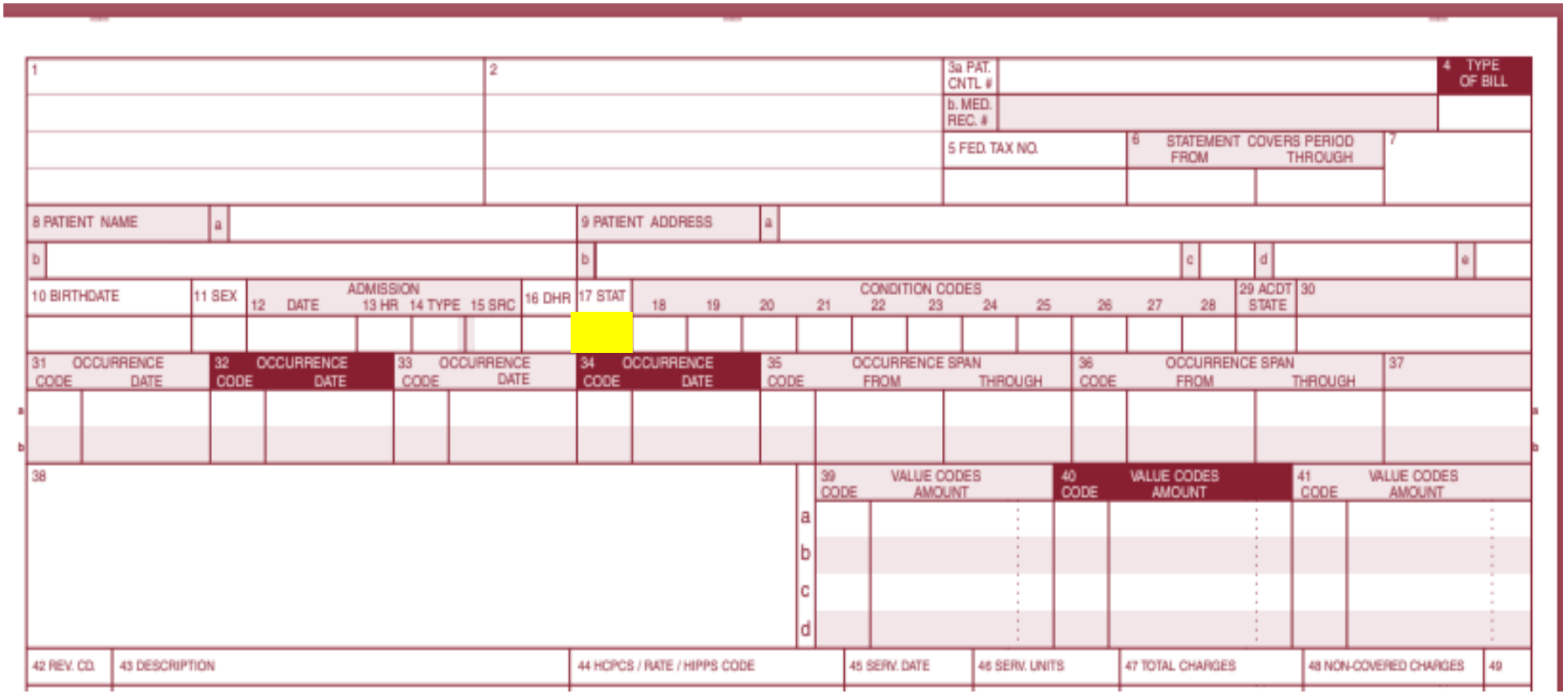
NOTE:

Outpatient bill types cannot have a value of '9'

UB04 Form – Field 17: Patient Status



Field 17: Patient Status

- Applies to IP admission only – Must contain a valid discharge status code
- IP bill types with a discharge frequency code (1 or 4) cannot have a discharge status of ’09’ or ‘30’ (still a patient)
- IP interim bill types can only have a discharge status of ‘09’ or ‘30’ (still a patient)

Common Denial Reason:

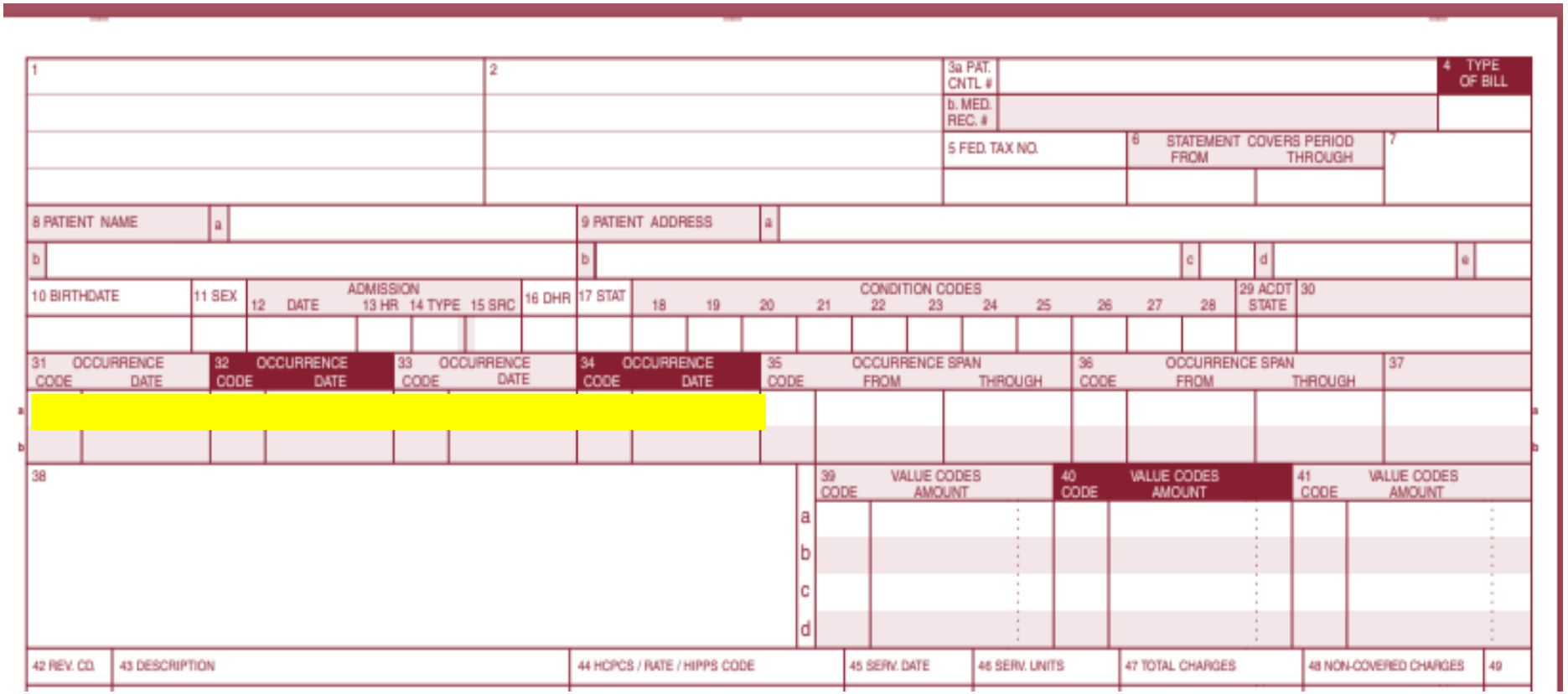
“Bill type discharge status conflict”

- IP Bill Types that end in a ‘1’ or ‘4’ cannot have a discharge status of ‘09’ or ‘30’
- IP Bill Types that end in a ‘2’ or ‘3’ (interim) can only be ‘09’ or ‘30’

Valid Discharge Status Code Descriptions

01	Discharged to self or home care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care.
04	Discharged/transferred to an intermediate care facility (ICF)
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
20	Expired
30	Still a patient
43	Discharge/Transferred to a Federal Healthcare 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 Inpatient 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 4/1/08: NOT USED (see code '05)

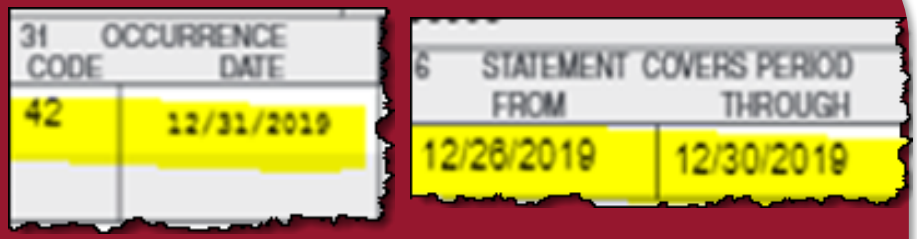
UB04 Form – Fields 31-34: Occurrence Codes



Fields 31-34: Occurrence Codes and Discharge Dates

- Required for in-patient bill types with a frequency code of ‘1’ or ‘4’ first/last claim
- Interim bill types (frequency code ‘2’ or ‘3’ first/continuing claim) cannot have a discharge date

Example



- Occurrence Code ‘42’ = Date of Discharge
- Through date in Statement Covers Period is NOT the actual discharge date, as Discharge is not included
- Discharge date must be one day after through date

Common Denial Reason:

“Discharge date is missing”

Discharge date required on in-patient bill types that end in a ‘1’ or ‘4’

“Discharge date must be outside of statement covered period”

Discharge date must not be part of statement covers period for in-patient bill types ending in a ‘1’ or ‘4’

“Invalid discharge date”

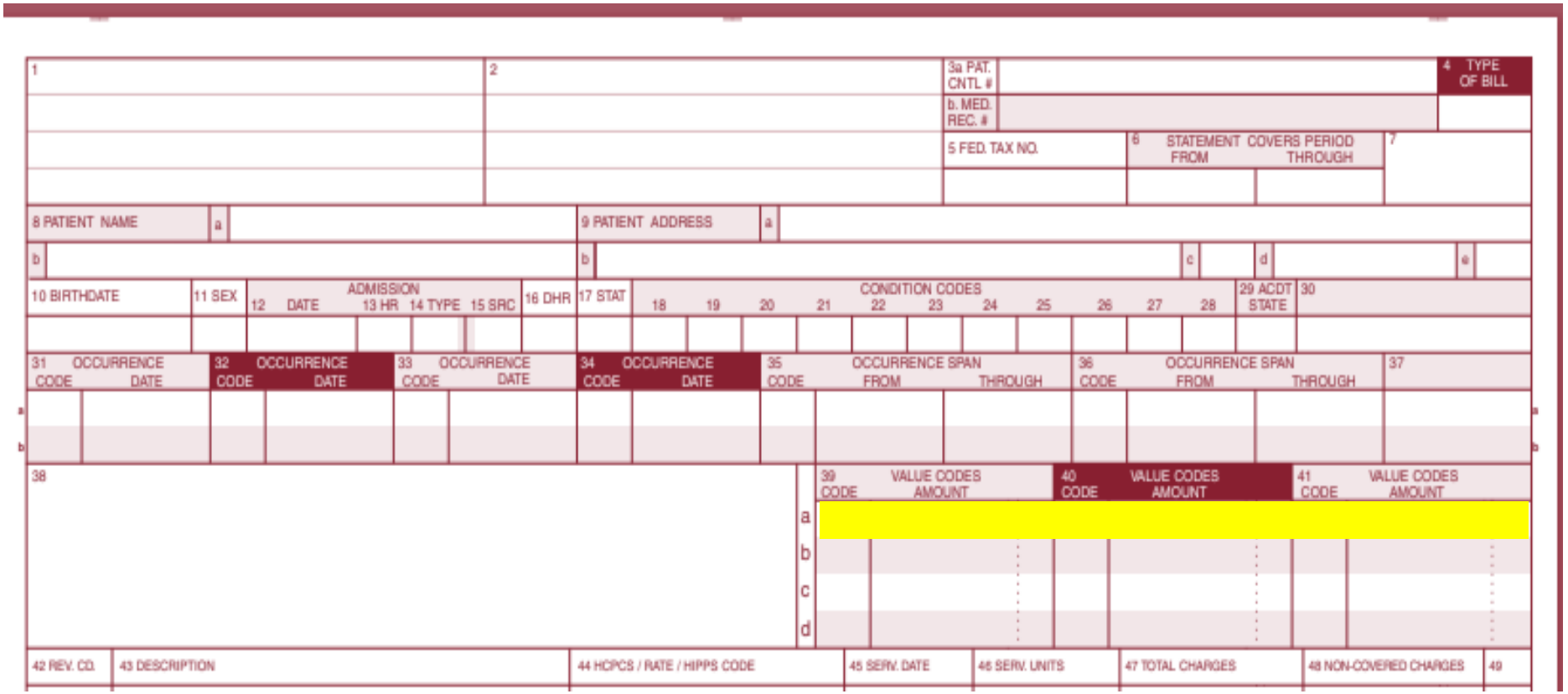
Discharge date <> Through date in Statement Covers Period + 1

“Discharge date conflict”

IP Interim claims cannot have a discharge date

Bill type 2, 3, cannot have discharge date

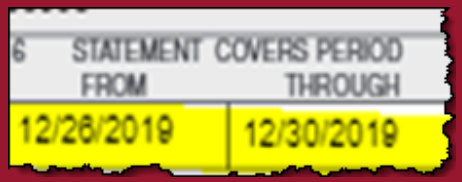
UB04 Form – Fields 39-41: Value Codes and Amounts



Fields 39-41: Value Codes and Amounts – Unit Validation

- Value Code ‘80’ denotes the number of covered days contained in the Amount box.
- The number of covered days must equal the number of days in the statement period (FL 6)

Example of 5 Covered Days



- Value Code ‘80’ indicates 5 covered days where the statement covers periods indicates 12/26-30.
- This shows an example of Covered Days counted correctly.

Covered Days	Date
1	12/26/2020
2	12/27/2020
3	12/28/2020
4	12/29/2020
5	12/30/2020

Common Denial Reason:

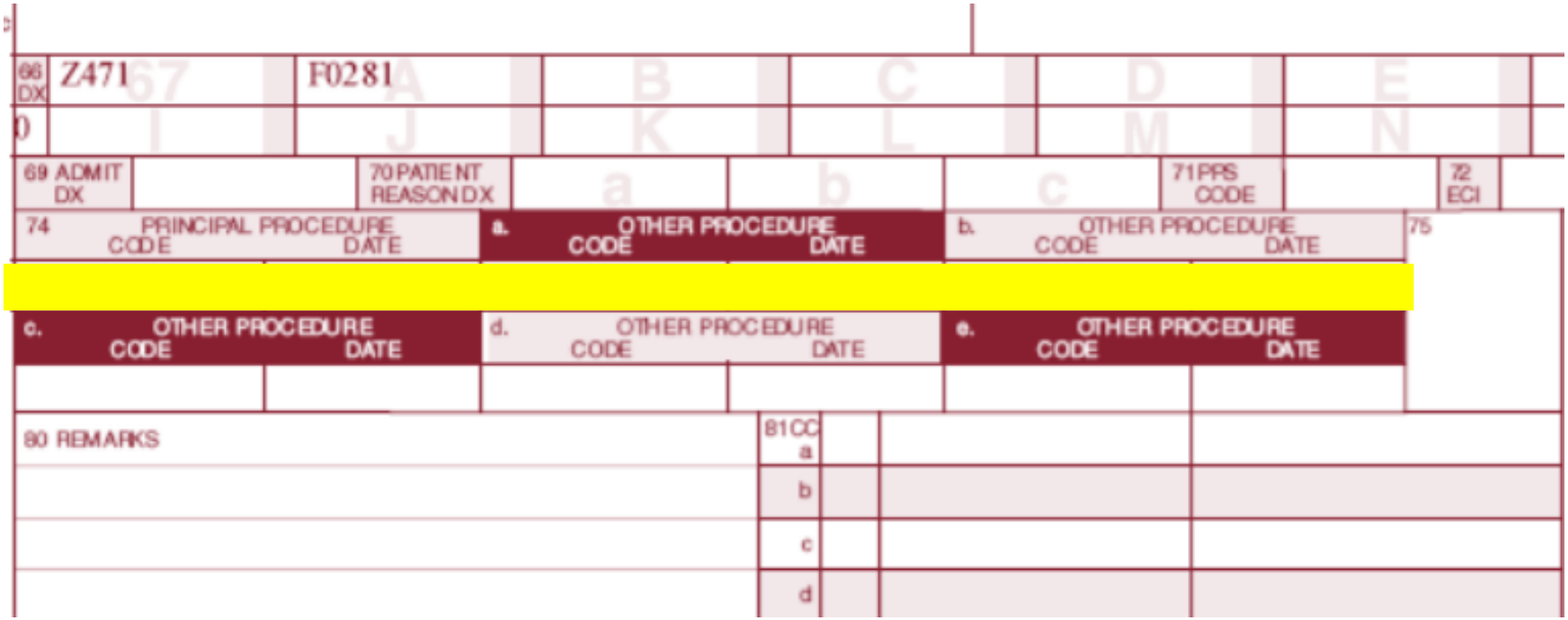
“Invalid/Missing number of units”

Value Code ‘80’ missing,

OR

'Value Code ‘80’ is present but Amount in box 39 (Number of Covered Days) does not equal the number of days in the Statement Period

UB04 Form – Field 74: Other Procedure Codes and Dates



66 DX	Z471	67	F0281	A	B	C	D	E
0		I		J	K	L	M	N

69 ADMIT DX		70 PATIENT REASON DX		a	b	c	71 PPS CODE		72 ECI	

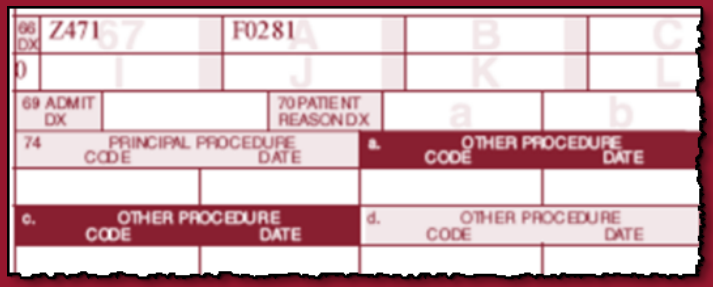
74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC a			
	b			
	c			
	d			

Field 74: Other Procedure Codes and Dates

- Required when billing ECT
- Procedure Code structure must be ICD-10-CM
- Date of Procedure must be entered
- Date must be format is MMDDYY

Rule



- When billing for ECT, include the primary ICD-10 procedure code in this field.

Common Denial Reason

"Field 74 required for procedure indicated by Revenue Code"

Denied when ECT or Anesthesia Revenue Code is submitted with no corresponding Other Procedure Code and Date.

Resources

MDH UB04 Billing Manual ***(Source of Truth)*** – Found on MDH site, Search: UB04 Billing Manual *(https://mmcp.health.maryland.gov)*

PBHS Fee Schedules – Found on Optum MD site, Search: Fee Schedules *(https://maryland.optum.com)*

Q & A Session

Please direct any outstanding questions to marylandproviderrelations@optum.com

Conclusion