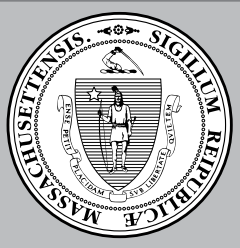
Residential Care Home

Billing Guide for the UB-04



Commonwealth of Massachusetts
Executive Office of Health and Human Services
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Introduction

Residential care homes choosing to submit their claims on paper must use the UB-04 claim form to submit their claims. This document provides detailed instructions for completing the paper UB-04 claim form.

Residential care home services are not covered by MassHealth. However, the Commonwealth of Massachusetts uses the MassHealth claims payment system to process claims on behalf of the Department of Transitional Assistance (DTA) for payment of residential care home services provided to residents receiving DTA assistance. For administrative purposes, MassHealth issues a 10-character identification number/service location code that permits residential care homes to submit claims through the MassHealth claims payment system.

For information about submitting claims electronically, see the *837I Companion Guide for Residential Care Homes*.

For information about the resulting remittance advice, see the MassHealth Residential Care Home Guide to the Remittance Advice for Paper Claims and Equivalents at www.mass.gov/masshealth. Go to MassHealth Regulations and Other Publications. Click on Provider Library and then on MassHealth Billing Guides for Paper Claim Submitters.

Please Note: Effective January 1, 2012, MassHealth adopted an all-electronic claims submission policy to achieve greater efficiency. All claims must be submitted electronically, unless the provider has received an approved electronic claim submission waiver. Ninety-day waiver requests and final deadline appeals may be submitted either electronically via the Provider Online Service Center (POSC) or on paper.

Please see All Provider Bulletin 217, dated September 2011, and All Provider Bulletin 223, dated February 2012, for more information about MassHealth's paper claims waiver policy. For information on how to submit 90-day waiver requests and final deadline appeals electronically, please also see All Provider Bulletin 220 and All Provider Bulletin 221, both dated December 2011, and All Provider Bulletin 226, dated June 2012.

General Instructions for Submitting Paper Claims

Entering Information on the UB-04 Claim Form

- Complete a separate claim form for each resident receiving DTA assistance.
- Type or print all applicable information (as stated in the instructions) on the claim form, using black ink only. Be sure all entries are complete, accurate, and legible.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as "same as above."
- When a required entry is a date, enter the date in MMDDYY or MMDDYYYY format.

Time Limitations on the Submission of Claims

Claims must be received within 90 days from the through date entered in Field 6 (Statement Covers Period) of the UB-04 claim form.

General Instructions for Submitting Paper Claims (cont.)

Electronic Claims

To submit electronic claims, refer to the 837I Companion Guide for Residential Care Homes or contact the Electronic Data Interchange (EDI) Department at 1-800-841-2900, Option 1, Option 8, then Option 3.

Please Note: When submitting electronic files to MassHealth, be sure to review this UB-04 billing guide, the 837I Companion Guide, and our Billing Tips flyers to determine the appropriate requirements for submitting electronic files to MassHealth. These documents can be found on the MassHealth web site at www.mass.gov/masshealth.

Where to Send Paper Claim Forms

Paper claims should be submitted to the following address.

MassHealth
Attn: Original Paper Claim Submissions
P.O. Box 9152
Canton, MA 02021

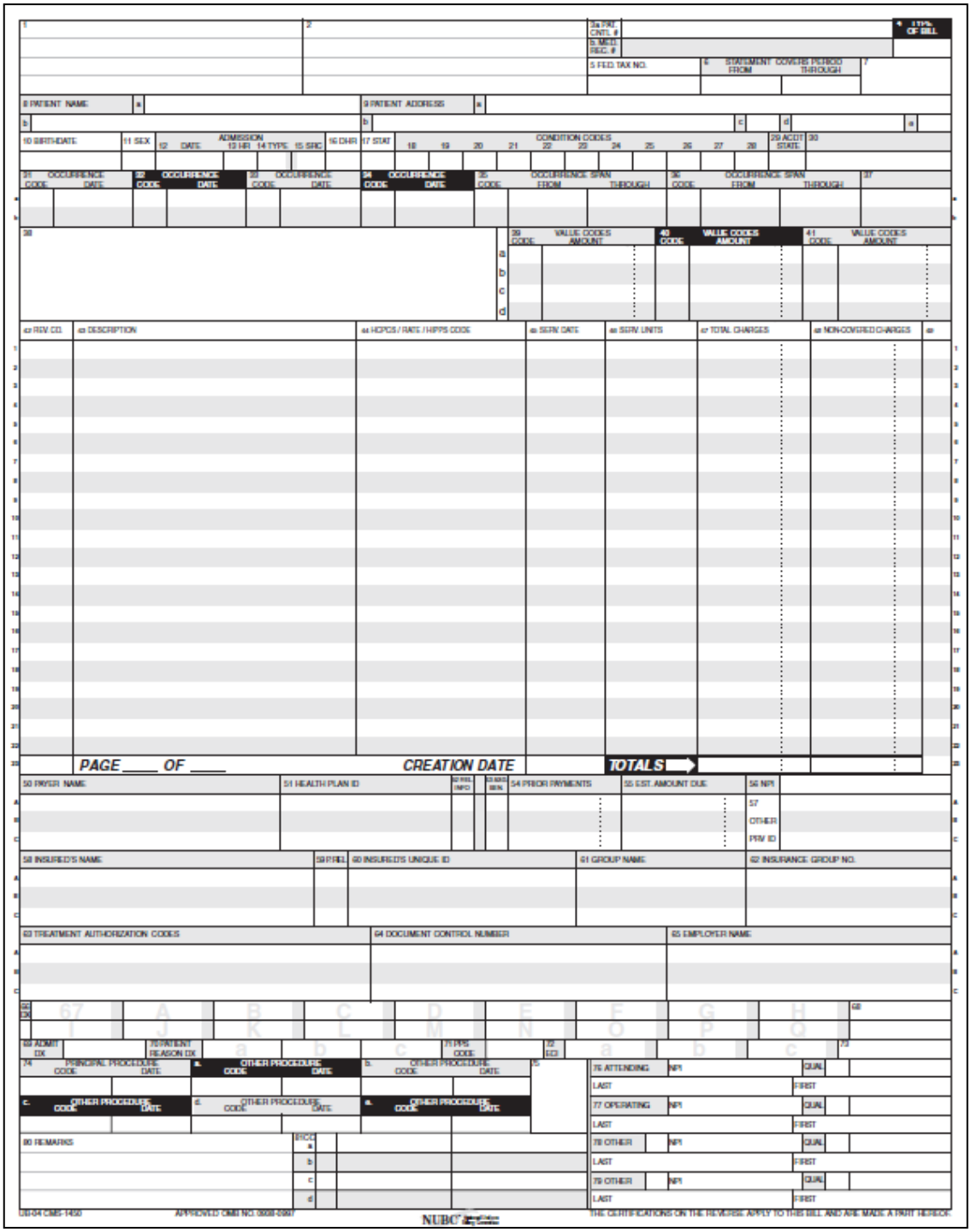
Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following field-by-field instructions, you need additional assistance to complete the UB-04 claim form, please contact MassHealth Customer Service at 1-800-841-2900.

How to Complete the UB-04 Claim Form

A sample of the front of the UB-04 claim form is shown below. A sample of the back of the form is on the next page. Following this sample are instructions for completing each field on the UB-04 claim form. Refer to the National Uniform Claim Committee (NUBC) instruction manual available at www.nubc.org.



How to Complete the UB-04 Claim Form (cont.)

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

How to Complete the UB-04 Claim Form (cont.)

Field No.	Field Name	Description
1	(Unnamed)	Enter the residential care home's name, doing business as (DBA) address, city, state, zip code, and telephone number. **Please Note:** The Billing Provider Address must be a street address. **Do not use** P.O. boxes or lock boxes.
2	(Unnamed)	Not required
3a	Pat Cntl #	Enter the resident control number, if it is assigned by the residential care home. If one is not assigned, enter the resident's last name.
3b	Med. Rec. #	Not required
4	Type of Bill	Residential care homes should use type of bill (TOB) 021x. Please refer to the list below. 0210 Nonpayment/Zero 0211 Admit through Discharge Claim 0212 Interim-First Claim 0213 Interim-Continuing Claim 0214 Interim-Last Claim 0215 Late Charges Only 0217 Replacement 0218 Void
5	Fed. Tax No.	Enter the residential care home's federal tax ID number.
6	Statement Covers Period From/Through	Enter the beginning and ending dates of the period included on this bill in MMDDYYYY format. Do not bill for more than one calendar month on a claim.
7	(Unnamed)	Not used
8a	Patient Name	Not required
8b	Patient Name	Enter the name of the resident in the following order: last name, first name, middle initial.
9a	Patient Address	Enter the street address of the residential care home.
9b	Patient Address	Enter the city of the residential care home.
9c	Patient Address	Enter the state of the residential care home.
9d	Patient Address	Enter the zip code of the residential care home.
9e	Patient Address	Not required
10	Birthdate	Enter the resident's date of birth in MMDDYYYY format.

How to Complete the UB-04 Claim Form (cont.)

Field No.	Field Name	Description
11	Sex	Enter an "M" or "F" to indicate the resident's gender.
12	Admission Date	Enter the date of the resident's initial admission to the residential care home or the date of the most recent readmission following a three-day hospital stay.
13	Admission Hr	Not required
14	Admission Type	Not required
15	Admission Src	Enter a code indicating the point of origin (source) for this admission or visit. Refer to the NUBC Instruction Manual for code values.
16	DHR	Not required
17	Stat	Enter the code indicating the disposition or discharge status of the resident at the end of the period covered on this bill, as reported in Field 6, Statement Covers Period. Refer to the NUBC Instruction Manual for code values.
18-28	Condition Codes	Not required
29	ACDT State	Not required
30	(Unnamed)	Not required
31-34	Occurrence Code/Date	Not required
35-36	Occurrence Span Code From Through	If applicable, enter the occurrence span code from the list below, for any medical leave of absence (MLOA) days or nonmedical leave of absence (NMLOA) days along with the associated dates of leave. 71 Prior stay dates - MLOA 74 First/last visit dates - NMLOA
37	(Unnamed)	Not used
38	(Unnamed)	Not required
39-41	Value Codes Code Amount	Enter value code 24 (Medicaid rate code) along with the total charges amount of the claim. (**Note:** The actual payer is DTA, but the Commonwealth uses the MassHealth claims payment system to process claims on behalf of DTA.) Enter value code 80 for covered days and the number of covered days. If a resident has a resident liability amount, on a separate line, enter value code FC and the resident liability amount.

How to Complete the UB-04 Claim Form (cont.)

Field No.	Field Name	Description
42 (Lines 1-22)	Rev Cd	Enter the applicable revenue code(s) as described below. • Enter **revenue code 100** for room and board days for residential care homes. • Enter **revenue code 183** for nonmedical-leave-of-absence (NMLOA) days. • Enter **revenue code 185** for medical-leave-of-absence (MLOA) days. If a resident has MLOA days or NMLOA days in the statement billed period, bill the revenue code and the number of room-and-board days (excluding MLOA and NMLOA days) on the first line with the number of room and board days in Field 46. Then, enter the revenue code for the MLOA days or NMLOA days on a different line with the appropriate revenue code and number of days in Field 46. The total number of room-and-board days and MLOA or NMLOA days should equal the number of covered days. When billing only for leave-of-absence days, do not include revenue code 100 for room-and-board days.
42 (Line 23)	Rev Cd	Enter revenue code 0001.
43 (Lines 1-22)	Description	Enter the appropriate description of the revenue code.
43 (Line 23)	Page__of __	Only single-page UB-04 claims are accepted. This should always be Page 1 of 1.
44 (Lines 1-22)	HCPCS/ Rates/HIPPS Code	Not required
45 (Lines 1-22)	Serv. Date	Not required
45 (Line 23)	Creation Date	Enter the date the claim form was submitted for reimbursement. This date cannot be earlier than the dates listed in field 6 of the UB-04. This is a required field.
46 (Lines 1-22)	Serv. Units	For each claim line, enter the total number of covered accommodation days defined by revenue code requirements.
47 (Lines 1-22)	Total Charges	For each claim line, enter the total charges that apply to the revenue codes entered in lines 1-22 in field 42. Do not deduct the resident's resident-liability amount from the total charge of the claim.

How to Complete the UB-04 Claim Form (cont.)

Field No.	Field Name	Description
47 (Line 23)	Total Charges (Totals)	Enter the total of all entries in this column on the bottom line. This is a required field.
48 (Lines 1-22)	Non-Covered Charges	Not required
48 (Line 23)	Non-Covered Charges (Totals)	Not required
49 (Lines 1-23)	(Unnamed)	Not used
50A-C	Payer Name	Enter "MassHealth." (**Note:** The actual payer is DTA, but the Commonwealth uses the MassHealth claims payment system to process claims on behalf of DTA.)
51A-C	Health Plan ID	Not required
52A-C	Rel Info	If applicable, enter the appropriate code for release of information. Refer to the NUBC Instruction Manual for code values.
53A-C	Asg. Ben.	Not required
54A-C	Prior Payments	Not required
55A-C	Est. Amount Due	Enter the amount estimated by the residential care home to be due from the indicated payer (estimated responsibility minus prior payments).
56	NPI	Enter the residential care home's 10-digit national provider identifier (NPI) if applicable. Residential care homes should enter the NPI only if they have an NPI on file with the MassHealth claims payment system. Otherwise, they must leave it blank.
57A-C	Other Prv ID	If you do not have an NPI, enter your 10-character MassHealth provider ID and service location.
58A-C	Insured's Name	Enter the name of the resident.
59A-C	P. Rel	Enter "self."
60A-C	Insured's Unique ID	Enter the resident's 12-character MassHealth ID. (**Note:** The actual payer is DTA, but the Commonwealth uses the MassHealth claims payment system to process claims on behalf of DTA.)
61A-C	Group Name	Not required
62A-C	Insurance Group No.	Not required

How to Complete the UB-04 Claim Form (cont.)

Field No.	Field Name	Description
63A-C	Treatment Authorization Codes	Not required
64A	Document Control Number (Line A only)	*For Adjustments:* When requesting an adjustment to paid claims, and the frequency code on the Type of Bill is "7" (Replacement of Prior Claim), enter an "A" followed by the 13-character internal control number (ICN) assigned to the paid claim. The ICN appears on the remittance advice on which the original claim was paid. When submitting an adjustment, include all lines that were on the original claim. Correct the line that needs to be adjusted. *For Resubmittals:* When resubmitting a denied claim, enter an "R" followed by the 13-character ICN assigned to the denied claim. The ICN appears on the remittance advice on which the original claim was denied.
64B-C	Document Control Number	Not required
65	Employer Name	Not required
66	DX	Enter the qualifier that denotes the version of International Classification of Diseases (ICD) reported.
67	(Unnamed)	Enter the ICD-CM diagnosis codes describing the principal diagnosis. Refer to the NUBC Instruction Manual for code values.
67(A-Q)	(Unnamed)	Enter the ICD-CM diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay. Refer to the NUBC Instruction Manual for code values.
68	(Unnamed)	Not used
69	Admit DX	Not required
70(a-c)	Patient Reason DX	Not required
71	PPS Code	Not required
72(a-c)	ECI	Not required
73	(Unnamed)	Not used

How to Complete the UB-04 Claim Form (cont.)

Field No.	Field Name	Description
74	Principal Procedure Code Date	Not required
74 (a-e)	Other Procedure Code Date	Not required
75	(Unnamed)	Not used
76	Attending NPI Qual Last First	Enter the name and NPI of the physician who is primarily responsible for the care of the resident reported in this claim.
77	Operating NPI Qual Last First	Not required
78-79	Other NPI Qual Last First	Not required
80	Remarks	Not required
81 (a-d)	CC	Not required