Maryland Medicaid
Hospice Services
UB04 Billing Instructions

July 30, 2007

Rev. 8/13/07

UB04 Hospice Instructions
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HOSPICE PROGRAM
UB04 Instructions for Billing Hospice Services

The uniform bill for hospice providers is known as the UB04 and is the replacement for the UB92 form. Starting July 30, 2007 all hospice paper claims must use the UB04; the UB92 will no longer be acceptable after this date.
The instructions are organized by the corresponding boxes or "Form Locators" on the paper UB-04 and detail only those data elements required for Medical Assistance (MA) paper claim billing. Hospice billing for Nursing Home Room and Board services will be separately listed in special instruction segments throughout this instruction manual. For electronic billing, please refer to the Maryland Medicaid 837-I Electronic Companion Guide, which can be found on our website at:

http://www.dhmh.state.md.us/hipaa/transandcodesets.html

The UB-04 is a uniform institutional bill suitable for use in billing multiple third party liability (TPL) payers. When submitting the above claims, complete all items required by each payer who is to receive a copy of the form.

Invoices for hospice care services must be received within nine (9) months of the month of service on the invoice. If a claim is received within the 9 month limit but rejected, resubmission will be accepted within 60 days of the date of rejection. If a claim is rejected because of late receipt, the patient may not be billed for that claim. If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted.

All third-party resources, such as insurance or Worker's Compensation, should be billed first and payment either received or denied before the Medical Assistance Program may be billed for any portion not covered. However, if necessary to meet the 9-month deadline for receipt of the claim(s), the Medical Assistance Program may be billed first and then reimbursed if the third-party payer makes payment later.

Invoices may be typed or printed. If printed, the entries must be legible. Do not use pencil or a red pen to complete the invoice. Otherwise, payment may be delayed or the claim rejected.

NOTE: Only hospice services provided during one calendar month can be billed on a UB-04.

Example: A hospice cannot bill for services provided for the period October 15th through November 14th on one UB04. One UB04 should include the October services and another UB04 should include the November services.

The Program has assigned hospices two different provider numbers for billing and reimbursement purposes. The billing instructions describe how the Hospice Institutional Provider Number and the Hospice Physician Services Provider Number are to be entered on the UB04. Providers must be careful to enter the correct provider number in the proper space when completing the form.

If a recipient is also eligible for Medicare Part A, the recipient must use the Medicare hospice benefit instead of the Medicaid hospice benefit, and the provider will bill Medicare for the recipient's hospice care. The provider may in addition use the UB04 to bill the Program, when appropriate, for the Medicare hospice benefit drug coinsurance and respite care coinsurance amounts and the room and board amounts for recipients who are nursing home residents.

Providers must use the CMS-1500 form (formerly the Health Insurance Claims Form, HCFA-1500) when billing the Program for the physician services component of hospice care. Claims for the CMS-1500 will be handled within the system in the same manner as the claims for a physician group. Should you have any questions about the use of the CMS-1500 form, please contact the Provider Relations Unit at the following numbers:

In the Baltimore Metropolitan Area:	(410) 767-5503
In Maryland Outside of Baltimore:	1-800-445-1159
Outside of Maryland:	1-800-492-5908

Providers must use the UB04 when billing the Program for all other hospice care services. Completed invoices for routine hospice care, continuous home, and respite inpatient care, general inpatient care are to be mailed to the following address:

Office of Operations, Eligibility and Pharmacy
Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

Completed invoices for hospice nursing home room and board are to be mailed to the following address:

Hospice Room and Board Claims
Maryland Medical Assistance
P.O. Box 17058
Baltimore, MD 21203

Providers will receive separate remittance advices and checks for services billed on the UB04 using the Hospice Institutional Provider Number and for services billed on the CMS-1500 using the Hospice Physician Service Provider Number.

UB04 Claim - Hospice Services (81X Type of Bill)

1 Billing Provider Name and Address	2 Medicaid ICN – Leave Blank	3a PAT. CNTL # / b. MED. REC. # Patient Control Number	4 TYPE OF BILL 81X
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH Covered Service Dates

8 PATIENT NAME	9 PATIENT ADDRESS
Patient Name: Last Name, First	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	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 CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a	Report when applicable					a
b						b

38	39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a **61** CBSA		
	b		
	c		
	d		

	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	Revenue Codes	Hospice Revenue Code Descriptions Optional.			Units	Total Charges			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE	Create Date	TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	NPI Number
A					When applicable		57 OTHER	Medicaid Legacy 9-digit Provider #
B							PRV ID	
C								

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			Patient'sMedical Assistance ID *Should always be last entry in field		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX | 67 I | A J | B K | C L | D M | E N | F O | G P | H Q | 68

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73
Principal Diag										

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

76 ATTENDING	NPI	QUAL
LAST		FIRST
77 OPERATING	NPI - required	QUAL **1D** 9-digit MA #
LAST	(#77 Hospice NPI / 9-digit MA Provider #)	
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

80 REMARKS	81CC		
Not Required - Optional	a		
	b		
	c		
	d		

UB-04 CMS-1450 OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB04 Claim - Hospice Nursing Home Room and Board (82X Type of Bill)

1 Billing Provider Name and Address	2 Medicaid ICN – Leave Blank	3a PAT. CNTL # / b. MED. REC. # Patient Control Number	4 TYPE OF BILL
			82x
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH: Covered Service Dates

8 PATIENT NAME	9 PATIENT ADDRESS
Patient Name: Last Name, First	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 CODE / DATE	32 CODE / DATE	33 CODE / DATE	34 CODE / DATE	35 CODE / OCCURRENCE SPAN FROM THROUGH	36 CODE / OCCURRENCE SPAN FROM THROUGH	37
a	Report when applicable					a
b						b

38	39 CODE / VALUE CODES AMOUNT	40 CODE / VALUE CODES AMOUNT	41 CODE / VALUE CODES AMOUNT
	a **61** CBSA		
	b		
	c		
	d		

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 **NH** Revenue Codes	**Nursing Home** Revenue Code Descriptions Optional.	HCPCS **Q5003** – every line item		Units	Total Charges		1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE ____ OF ____	CREATION DATE Create Date		TOTALS			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	NPI Number
A				When applicable		57 OTHER PRV ID	Medicaid Legacy 9-digit Provider #
B							
C							

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A		Patient'sMedical Assistance ID *Should always be last entry in field		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX	A	B	C	D	E	F	G	H	68
Principal Diag	I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

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	

76 ATTENDING	NPI	NPI - required	QUAL	1D	9-digit MA #
LAST		(#76 Nursing Home NPI / 9-digit MA Provider #)	FIRST		
77 OPERATING	NPI	NPI - required	QUAL	1D	9-digit MA #
LAST		(#77 Hospice NPI / 9-digit MA Provider #)	FIRST		
78 OTHER	NPI		QUAL		
LAST			FIRST		
79 OTHER	NPI		QUAL		
LAST			FIRST		

80 REMARKS	81CC	
Not Required - Optional	a	
	b	
	c	
	d	

UB-04 CMS-1450 © 2005 NUBC — OMB APPROVAL PENDING — NUBC National Uniform Billing Committee LIC9213257 — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

The instructions that follow are keyed to the form locator number and headings on the UB04 form.

FL 01 **Billing Provider Name, Address, and Telephone Number**

Required. Enter the name and service location of the provider submitting the bill.

Line 1 Enter the provider name filed with the Medical Assistance Program.

Line 2 Enter the street address to which the invoice should be returned if it is rejected due to provider error.

Line 3 Enter the City, State & full nine-digit ZIP Code

Line 4 Telephone, Fax, County Code (Optional)

Note: Checks and remittance advices are sent to the provider's address as it appears in the Program's provider master file.

FL 02 **Pay-to Name and Address**

Leave Blank – Internal Use Only

FL 03a **Patient Control Number**

Required. Enter the patient's unique alphanumeric control number assigned to the patient by the hospital. A maximum of 20 positions will be returned on the remittance advice to the provider.

FL 03b **Medical/Health Record Number**

Optional. Enter the medical/health record number assigned to the patient by the hospital when the provider needs to identify for future inquiries the actual medical record of the patient. Up to 13 positions may be entered.

FL 04 **Type of Bill**

Required. Enter the 3-digit code (**do not report leading zero**) indicating the specific type of bill. Entering the leading zero will cause your claim to deny. The third digit indicates the bill sequence for this particular episode of care and is referred to as a "frequency" code. All three digits are required to process a claim.

Only those "Types of Bills" listed are acceptable by Medical Assistance for Hospice services. The "x" in the Type of Bill column of the matrix represents a placeholder for the frequency code. A list of the frequency codes follows the matrix. Only those highlighted in grey are used by Medical Assistance.

Type of Bill	Description	Inpatient/Outpatient General Designation
081x	Specialty Facility – **Hospice Facility Services**	IP
082x	Specialty Facility – Hospice **Nursing Home Room and Board Services**	IP

Type of Bill Frequency Codes:		
1	Admit Through Discharge Claims	The provider uses this code for a bill encompassing an entire inpatient confinement for which it expects payment from the payer.
2	Interim Billing - First Claim	This code is to be used for the first (admit) of an expected series of bills for the same confinement or course of treatment for which the provider expects payment from the payer. FL 17 should equal "30".
3	Interim Billing- Continuing Claim	This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted for which payment is expected from the payer. FL 17 should equal "30".
4	Interim Billing - Last Claim	This code is to be used for the last (discharge) of a series of bills for the same confinement or course of treatment for which payment is expected from the payer.
7	Replacement of Prior Claim FUTURE USE – NOT USED	This code is to be used when a specific bill has been issued for a specific provider, patient, payer, insured and "statement covers period" and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principal that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill. This code is not intended to be used in lieu of a Late Charge(s) Only claim.
8	Void/Cancel of Prior Claim FUTURE USE – NOT USED	This code reflects the elimination in its entirety of a previously submitted bill for a specific provider, patient, insured and "statement covers period" dates. The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.

Type of Bill Frequency Codes:		
A	Admission/Election Notice NOT USED	This code is used when a hospice, home health agency, CMS Coordinated Care Demonstration entity, Centers of Excellence Demonstration entity, Provider Partnerships Demonstration entity or Religious Non-medical Health Care Institution is submitting the UB04 as an admission or election notice.
B	Hospice/CMS Coordinated Care Demonstration/Reglions Non-Medical Health Care Institution/ Centers of Excellence Demonstration/Provider Partnerships Demonstration NOT USED	This code is used when the UB04 is used as a Termination/Revocation of a hospice, CMS Coordinated Care Demonstration entity, Centers of Excellence Demonstration entity, Provider Partnerships Demonstration entity or Reglions Non-Medical Health Care Institution election.
C	Hospice Change of Provider Notice NOT USED	Use when the UB04 is used as a Notice of Change to the hospice provider
D	Hospice/CMS Coordinated Care Demonstration/Reglions Non-Medical Health Care Institution/ Centers of Excellence Demonstration/ Provider Partnerships Demonstration Void/Cancel NOT USED	This code is used when the UB04 is used as a Notice of a Voice/Cancel of a hospice, CMS Coordinated Care Demonstration entity, Centers of Excellence Demonstration entity, Provider Partnerships Demonstration entity or Reglions Non-Medical Health Care Institution election.
E	Hospice Change of Ownership NOT USED	This code is used to indicate a Notice of Change in ownership for the hospice.

Note: Frequency codes "7" and "8" will be available in the future. Do not use them until notified of their availability. Use of these codes currently will result in rejection of your invoice.

FL 05 **Federal Tax Number**

Not required. The number assigned to the provider by the federal government for tax reporting purposes. The format is: NN-NNNNNNN; 10 positions (include hyphen). For electronic claims, do not report the hyphen.

FL 06 **Statement Covers Period (From - Through)**

Required. Enter the "From" and "Through" dates of the period covered by this invoice (MMDDYY). Do not show dates before the patients entitlement began.

NOTE: When billing for services rendered on the date of death be sure to include the date of death as your "Through" date. A hospice should not "split" a Medical Assistance bill for hospice services provider during one calendar month, unless there is a gap in the patient's hospice care enrollment during the month that results in a new admission date.

FL 07 **Reserved for Assignment by NUBC**

NOT USED

FL 08a **Patient Name – Identifier**

Not required.

FL 08b **Patient Name**

Required. Enter the patient's name as it appears on the Medical Assistance card: last name, first name, and middle initial. (Please print this information clearly.)

FL 09, 1a-2e **Patient Address**

Optional. Enter the patient's complete mailing address, as follows:

Line 1a -- Enter the patient address – Street (or P.O. Box)
Line 2b -- Enter the patient address – City
Line 2c -- Enter the patient address – State
Line 2d -- Enter the patient address –Zip
Line 2e -- Enter the patient address –Country Code (Report if other than USA)

FL 10 **Patient Birth Date**

Required. Enter the month, day, and year of birth (MMDDYYYY). Example: 11223333

FL 11 **Patient Sex**

Not required. Enter the patient's sex as recorded at admission, outpatient service, or start of care.

M – Male F – Female U – Unknown

FL 12 **Admission/Start of Care Date**

Required. Enter the start date for this episode of care. Enter the date as (MMDDYY).

For hospice services this date must be the same date as the effective date of the hospice election or change of hospice care provider. The date of admission may not precede the physician's certification by more than 2 calendar days.

Example:
The Hospice election is November 1st. The physician's certification is dated November 10th. The hospice (admission) date for coverage and billing is November 8th. The first hospice benefit period will end 90 days from November 8th. Enter year as MMDDYY.

FL 13 **Admission Hour**

Required. Enter the code for the hour during which the patient was admitted for inpatient care from the following table:

CODE STRUCTURE:

Code	Time	Code	Time
00	12:00-12:59 Midnight	12	12:00-12:59 Noon
01	01:00-01:59	13	01:00-01:59
02	02:00-02:59	14	02:00-02:59
03	03:00-03:59	15	03:00-03:59
04	04:00-04:59	16	04:00-04:59
05	05:00-05:59	17	05:00-05:59
06	06:00-06:59	18	06:00-06:59
07	07:00-07:59	19	07:00-07:59
08	08:00-08:59	20	08:00-08:59
09	09:00-09:59	21	09:00-09:59
10	10:00-10:59	22	10:00-10:59
11	11:00-11:59	23	11:00-11:59

FL 14 **Priority (Type) of Visit**

Required. Enter the code indicating priority of this admission.

Code Structure – Priority (Type of Visit)		
3	Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.

FL 15 **Source of Referral for Admission or Visit**

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

Code Structure: Source of Referral for Admission or Visit		
1	Physician Referral	The patient was admitted to this facility upon the recommendation of his or her personal physician.
2	Clinic Referral	The patient was admitted to this facility upon recommendation of this facility's clinic physician.
3	HMO Referral	The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.
4	Transfer from a Hospital (Different Facility*) *For transfers from Hospital Inpatient in the Same Facility, see Code D	The patient was admitted to this facility as a hospital transfer from a different acute care facility where he or she was an inpatient.

Code Structure: Source of Referral for Admission or Visit		
5	Transfer from a Skilled Nursing Facility	The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was a resident.
6	Transfer from Another Health Care Facility	The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.
7	Emergency Room	The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.
8	Court/Law Enforcement	The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
A	Transfer From a Critical Access Hospital	The patient was admitted to this facility as a transfer from a Critical Access Hospital where he or she was an inpatient.
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer	The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

FL 16 **Discharge Hour**

Not required.

FL 17 **Patient Discharge Status**

Required. Enter a code from the code structure below indicating the patient's disposition or discharge status at the time of billing for that period of inpatient care.

Code Structure: Patient Discharge Status	
01	Discharged to self or home care (routine discharge) Usage Notes: Includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.
20	Expired
30	Still a patient Usage Notes: Used when patient is still within the same facility; typically used when billing for leave of absence days or interim bills.
40	Expired at Home Usage Notes: For use only on Medicare and TRICARE claims for hospice care.

Code Structure: Patient Discharge Status	
41	Expired in a Medical Facility (eg. Hospitals, SNF, ICF, Free-Standing Hospice) Usage Notes: For use only on Medicare & TRICARE claims for Hospice
42	Expired – Place Unknown Usage Notes: For use only on Medicare & TRICARE claims for Hospice
50	Hospice – Home
51	Hospice – Medical Facility (Certified) Providing Hospice Level of Care

FL 18-28 **Condition Codes**

Not Required.

FL 29 **Accident State**

Not required.

FL 30 **Reserved for Assignment by NUBC**

Not Used

FL 31-34 a b **Occurrence Codes and Dates**

Required when there is an Occurrence Code that applies to this claim. Enter the code and associated date defining a significant event relating to this bill that may affect payer processing. Enter all dates as MMDDYY.

The Occurrence Span Code fields can be utilized to submit additional Occurrence Codes when necessary by leaving the THROUGH date blank in FL 35-36. As a result, up to 12 Occurrence Codes may be reported.

Report Occurrence Codes in alphanumeric sequence (numbered codes precede alphanumeric codes) in the following order: FL 31a, 32a, 33a, 34a, 31b, 32b, 33b, 34b. If there are Occurrence Span Code fields available, fields 35a FROM, 36a FROM, 35b FROM and 36b FROM may then be used as an overflow. After all of these fields are exhausted, FL 81 (Code-Code field) can be used with the appropriate qualifier (A2) to report additional codes and dates (see FL 81 for additional information).

Enter the appropriate codes and dates from the table below.

Note A: Occurrence Codes should be entered in alphanumeric sequence. However, report any Occurrence Codes required to process your Maryland Medicaid claim first; then continue to report other Occurrence Codes as needed in alphanumeric sequence. Maryland Medicaid will only capture 12 Occurrence Codes, including those reported in FL 81.

Note B: Any hospital inpatient Type of Bill (TOB) with frequency codes 1or 4 must report occurrence Code 42 - Date of Death/Discharge.

Code Structure – Occurrence Codes & Dates:		
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the hospital from any insurer.
25	Date Benefits Terminated by Primary Payer	Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
27	Date of Hospice Certification or Re-Certification	The date of certification or re-certification of the hospice benefit period.
42	Date of Discharge	For hospice services, enter the date of death or the date the Medicare beneficiary terminated his election of hospice care.

Note C: Please use the appropriate third-party liability override codes 24 or 25 when the patient has other insurance coverage but the services are not covered or were rejected by the insurer.

FL 35-36a b Occurrence Span Codes and Dates

Not Required**.**

FL 37 NOT USED

FL 38 Responsible party name and address

Not required.

FL 39-41 a-d Value Codes and Amounts

Required when there is a Value Code that applies to this claim. A code structure to relate amounts or values to data elements necessary to process this claim as qualified by the payer organization.

Enter Value Codes in alphanumeric sequence. FLs 39a - 41a must be completed before the 'b' fields, etc. Whole numbers or non-dollar amounts are right-justified to the left of the dollars/cents delimiter. Do not zero fill the positions to the left of the delimiter. Negative numbers are not allowed except in FL 41.

If all the Value Code fields are filled, use FL 81 Code-Code field with the appropriate qualifier code (A4) to indicate that a Value Code is being reported (see FL 81 for more information).

Note A: Value Codes should be entered in alphanumeric sequence. However, report any Value Codes required to process your Maryland Medicaid claim first; then continue to report other Value Codes as needed in alphanumeric sequence. Maryland Medicaid will only capture 12 Value Codes, including those reported in FL 81.

Code Structure – Value Codes and Amounts:		
23	Recurring Monthly Income	Enter the patient monthly resource amount as indicated on the DHMH 4233, Notice of Eligibility letter.
61	Location Where Hospice Service is Furnished: 12580: Baltimore/Towson 47894: Washington, DC 41540: MD Rural Area 48864: DE-MD-NJ 25180: Hagerstown 19060: Cumberland 13644: Bethesda/Gaithersburg	Core Based Statistical Area (CBSA) number of the location where the hospice service is delivered. Enter one of the 7 Federal CBSA values listed to the left. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
80[(a)]	Covered days	The number of days covered by the primary payer as qualified by the payer.

[(a)] *Do not use on v. 004010/004010A1 837 electronic claims (use Claim Quantity in Loop ID 2300 | QTY01 instead).*

Note B: Code 61 ***must*** be entered on all 81x or 82x Type of Bill Hospice submissions to indicate the CBSA location of the hospice services being rendered. Claims will deny if this information is not entered on your claims.

Note C: Code 80 replaces UB form locator for covered days. This value code must be entered, showing the number of covered days billed.

FL 42 Revenue Codes

Required. Line 1-23. Enter the appropriate four-digit numeric revenue code from the enclosed Hospice Revenue Code Matrix below to identify specific accommodation and/or ancillary charges.
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 for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

To assist in bill review, revenue codes should always be listed in ascending numeric sequence, by date of service (outpatient). The exception is Revenue Code 0001, which is used on paper claims only and is reported on Line 23 of the last page of the claim. On inpatient claims, accommodations must be entered first on the bill and in revenue code sequence. Revenue codes must not be repeated on the same bill.

065X Hospice Service

Charge for hospice care services for a terminally ill patient electing hospice services in lieu of other medical services for their terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medical Assistance payment for that day.

	Subcategory	Standard Abbreviation
0	General Classification (Medicare Respite Coinsurance)	HOSPICE/RESPITE CO-INS
1	Routine Home Care	HOSPICE/RTN HOME
2	Continuous Home Care	HOSPICE/CTNS HOME
5	Inpatient Respite Care	HOSPICE/IP RESPITE
6	General Inpatient Care Non-Respite	HOSPICE/IP NON-RESPITE
9	Other Hospice Service	HOSPICE/OTHER

Note: Each reimbursement element identified by a revenue code is subject to MMAP limitations and conditions that are set forth in regulations and policy instructions. For example, to bill for Continuous Home Care under Revenue code 0652 a minimum of 8 hours of defined care must be furnished in a 24-hour period, and a portion of an hour of such care must be furnished in a 24-hour period, and a portion of an hour of such care is counted as an hour when billing. Providers must comply with the applicable limitations and conditions when billing for hospice care services.

SPECIAL INSTRUCTIONS FOR 82X HOSPICE ROOM AND BOARD BILLING:

Enter into FL 42 the Nursing Facility services revenue codes reported to the Hospice from the Nursing Facility where the patient resides. In FL 44 (HCPCS field) report the CMS HCPCS code Q5003 – Hospice Care Provided in a Nursing Long Term Care (LTC) Facility or Non-Skilled Nursing Facility (NF). Report this code on every line item where a nursing facility revenue code is reported.

Example:

42 REV CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV/DATE	46 SERV/UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0190	Rm. & Bd. Semi-Private	Q5003		30	5481 : 75		
0230	Turning & Positioning	Q5003		30	233 : 99		
0001	Total Charges				5715 : 74		

NOTE: Hospice Room and Board claims will be priced off of the nursing facility revenue codes reported on the UB04 and the nursing facility provider number reported in FL 76.

FL 43 **Revenue Descriptions**

Optional. Enter a narrative description or standard abbreviation for each revenue code shown in FL 42. Descriptions or abbreviations will correspond to the revenue codes shown in the **Revenue Code Matrix** included in these Instructions.

SPECIAL INSTRUCTIONS FOR 82X HOSPICE ROOM AND BOARD BILLING:

Optional. Enter a narrative description or standard abbreviation for each Nursing Facility revenue code shown in FL 42.

FL 44 **HCPCS/Accommodation Rates/HIPPS Rate Codes**

HCPCS:
Not required for hospice routine service billing.

HCPCS Modifiers:
Not required.

Accommodation Rates:
Not required. Enter the accommodation rate for inpatient bills.

HIPPS:
Not required.

SPECIAL INSTRUCTIONS FOR 82X HOSPICE ROOM AND BOARD BILLING:

HCPCS:
Required. Report the CMS HCPCS code Q5003 – Hospice Care Provided in a Nursing Long Term Care (LTC) Facility or Non-Skilled Nursing Facility (NF). Report this code on every line item where a nursing facility revenue code is reported. See example in FL 42 (Revenue Codes).

The field contains 5 positions for the base code, plus 8 positions for up to 4 HCPCS modifiers (not required).

FL 45 **Service Date**

Line 1-22: Not required. Enter the date (MMDDYY) the outpatient service was provided.

Line 23: Enter Creation Date (MMDDYY)
Required. Enter the date the bill was created or prepared for submission. Creation Date on Line 23 should be reported on all pages of the UB04.

FL 46 **Units of Service**

Required. Enter the total number of **covered** days or units of service for every revenue code reported except 0001.

FL 47 **Total Charges**

Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period (FL 06).

Line Item Charges
Required - Lines 1-22. Line items allow up to nine numeric digits (0,000,000.00); 7 positions for dollars, 2 positions for cents.

Total (Summary) Charges
Required - Line 23 of the final claim page using Revenue Code 0001. MMAP will pay 95% of the allowed charges, minus the patient resources.

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 for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

(Revenue code 0001 is not used on electronic transactions; report the total claim charge in the appropriate data segment/field according to the electronic companion guides).

FL 48 **Non-Covered Charges**

Not required.

FL 49 **Reserved for Assignment by NUBC**

NOT USED

FL 50 a,b,c **Payer Name**

Optional.

First line, 50a is the Primary Payer Name.
Second line, 50b is the Secondary Payer Name.
Third line, 50c is the Tertiary Payer Name.

Multiple payers should be listed in priority sequence according to the priority in which the provider expects to receive payment from these payers.

Note: If other payers listed, Medicaid should be the last entry in this field.

FL 51 a,b,c **Health Plan Identification Number**

Not required.

FL 52 a,b,c **Release of Information Certification Indicator**

Not required.

FL 53 a,b,c **Assignment of Benefits Certification Indicator**

Not required.

FL 54 a,b,c **Prior Payments - Payer**

Required when the indicated payer has paid an amount to the provider towards this bill. Enter the amount the provider has received (to date) by the health plan toward payment of this bill. DO NOT REPORT MEDICARE PRIOR PAYMENTS IN THIS FIELD.

FL 55 a,b,c **Estimated Amount Due**

Not required.

FL 56 **National Provider Identifier (NPI) – Billing Provider**

Required. The unique identification number assigned to the provider submitting the bill; NPI is the 10-digit national provider identifier. Beginning on the Medical Assistance NPI compliance date of July 30, 2007, the Hospice Facility must report its organizational health care NPI in FL 56.

Note A: Organizational health care providers must continue to report proprietary legacy identifiers necessary for Maryland Medicaid to identify the Billing Provider entity in FL 57 Lines a-c.

Note B: Hospice facilities must report Value Code 61 – CBSA location in FL 39-41 for appropriate crosswalk to Maryland Medicaid legacy 9-digit provider number.

FL 57 a,b,c **Other (Billing) Provider Identifier - Legacy**

Required. A unique identification number assigned to the provider submitting the bill by the health plan. Enter the Maryland Medicaid Legacy 9-digit provider number.

The UB04 does not use a qualifier to specify the Other (Billing) Provider Identifier. Use this field to report other provider identifiers as assigned by the health plan (as indicated in FL50 Lines a-c).

FL 58 a,b,c **Insured's Name**

Not required.

FL 59 a,b,c **Patient Relationship to Insured**

Not required.

FL 60 a,b,c **Insured's Unique ID**

Required. Enter the 11-digit Medical Assistance number of the insured as it appears on the Medical Assistance card. If billing for a newborn, you must use the newborn's Medical Assistance number.

If there are other insurance numbers shown, such as Medicare, then the Medicaid identification number should appear last in the field.

REMINDER:

Providers may verify a patient's current Medical Assistance eligibility by calling the Eligibility Verification System/Interactive Voice Response (EVS/IVR) line:

Toll-Free Number for the entire State: **1-866-710-1447**

WebEVS: Providers may verify a patient's current Medical Assistance eligibility by using the new web-based eligibility services available for providers who are enrolled in EMedicaid. To access this service, click on: www.emdhealthchoice.org

FL 61 a,b,c **Insured's Group Name**

Not required.

FL 62 a,b,c **Insured's Group Number**

Not required.

FL 63 a,b,c **Treatment Authorization Code**

Not required.

FL 64 a-c **Document Control Number (DCN)**

FUTURE USE. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Required when Type of Bill Frequency Code (FL 04) indicates this claim is a replacement or void to a previously adjudicated claim.

FL 65 **Employer Name (of the Insured)**

Not required.

FL 66 **Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**

Not Required.

FL 67 **Principal Diagnosis Code and Present on Admission Indicator**

Principal Diagnosis Code

Required. Enter the 5-digit ICD-9-CM code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). Always code to the most specific level possible, but do not enter any decimal points when recording codes on the UB04.

Present on Admission (POA) Indicator – **Not Required: All Fields**

FL 67 a-q **Other Diagnosis Codes**

Not Required.

FL 68 **Reserved for Assignment by NUBC**

NOT USED

FL 69 **Admitting Diagnosis**

Not required.

FL 70 a,b,c **Patient's Reason for Visit Code**

Not required.

FL 71 **Prospective Payment System (PPS) Code**

Not Required**.**

FL 72 a-c **External Cause of Injury Code (ECI or E-Code)/POA Indicator**

Not required.

FL 73 **Reserved for Assignment by NUBC**

NOT USED

FL 74 **Principal Procedure Code and Date**

Not required.

FL 74 a-e **Other Procedure Codes and Dates**

Not required.

FL 75 **Reserved for Assignment by NUBC**

NOT USED

FL 76 **Nursing Facility Provider Name and Identifiers**

SPECIAL INSTRUCTIONS FOR 82X HOSPICE ROOM AND BOARD BILLING ONLY:

Required. The Nursing Facility billing the Hospice provider for room and board and ancillary services should provide the Hospice with their 10-digit organizational NPI number.

Line 1 Enter the 10-digit organizational NPI number assigned to the nursing facility where the hospice patient resides. If the nursing facility organizational NPI number is missing or incorrect, Hospice Room and Board claims cannot be priced and claims will deny.

Line 1 Secondary Identifier Qualifiers: **Required.**
1D – Medicaid Legacy Provider Number.
Enter the 9-digit Maryland Medicaid legacy provider number assigned to the nursing facility by the Maryland Medicaid Program.

Line 2 Nursing Facility Name - Not required.

FL 77 **Hospice Physician Name and Identifiers**

Required on all Hospice Facility services billing (81x and 82x claims).

Line 1 Enter the 10-digit Individual NPI number assigned to the Hospice Facility physician provider. You must enter the Hospice Physician NPI number to assure that your claim will validate against the patient's hospice enrollment certification on file or your claims will deny.

Line 1 Secondary Identifier Qualifiers:
1D – Medicaid Legacy Provider Number.
Enter the 9-digit Maryland Medicaid Hospice Facility Physician number assigned by the Maryland Medicaid Program.

Line 2 Hospice Physician Name - Not required.

FL 78 & 79 **Other Provider (Individual) Names and Identifiers**

Not required.

FL 80 **Remarks**

Not required.

FL 81 a-d **Code-Code Field**
Not required.