

UB-04 Instructions

Hospital, nursing facility (NF), and intermediate care facility (ICF) providers must use the UB-04 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under the Kansas Medical Assistance Program (KMAP). Claims can be submitted on the KMAP secure website, as an electronic 837 file, through Provider Electronic Solutions (PES), or on an original, red ink UB-04 paper claim form.

When a paper claim is submitted for a KMAP beneficiary, KMAP must be indicated on the form and the form should be completed using the instructions indicated below. Claims not meeting these submission requirements will be returned to the provider. KanCare (managed care) claims should be submitted to the appropriate KanCare managed care organization (MCO).

The fiscal agent does not furnish the paper UB-04 claim forms to providers. The form must be obtained from a claim form supplier, such as the one listed below.

Advantage Business Forms
211 Southwest 6th
Topeka, KS 66603
785-235-6868

Send completed paper claim to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

Note: For all paper claims, the Kansas MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

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Nursing facility only

If the stay meets Medicare-coverage criteria, Medicare reimburses the NF for the first 20 days and there is no coinsurance or deductible. If after day 20 the stay is still covered by Medicare, days 21 to 100 are reimbursed by Medicare for all but the Medicare coinsurance and deductible. This coinsurance and deductible can be billed to KMAP on the UB-04 (electronic or paper) using your KMAP provider number and indicating the type of bill (TOB) 21X, 65X, or 66X after Medicare has paid its eligible portion.

Medicare coinsurance claims

- If Medicare is involved in the payment of the claim, the explanation of benefits (EOB)/remittance advice (RA) from Medicare **must** be included with the submission of the paper UB-04 paper claim.
- When submitting a paper claim, do not put Medicare payment information in the **Other Insurance** field, or the claim will be denied.
- When the Medicare payment equals or exceeds the lowest of the Medicaid or Medicare allowable, HIPAA claim adjustment reason code (CARC) 23 and EOB code 0095 are applied and will appear on the RA. The claim is paid zero dollars because Medicare paid the maximum allowable.

If the claim contains room and board with ancillary services **and** the provider received **Part A and B** payment, the claim will be processed through the Medicare Algorithm for the **Part A** payment and the **Part B** payment will be applied as a TPL payment. If only a **Part B** payment has been made, indicate in Box 50, "Medicare Part B only". If the provider bills only ancillary services, those claims will be denied as content of service to the room and board claim.

If **Part A** coverage is exhausted before or during the patient's stay, use Condition Code 67 (Beneficiary elects not to use lifetime reserve days) or Occurrence Code A3 (Benefits exhausted) and put the date the benefits were exhausted on the claim. If Condition Code 67 is used, the Occurrence Code A3 and corresponding date must be present.

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Billing Instructions

The following numbered form locators (FL) are to be completed when required or if applicable.

NOTE: For all fields requiring a National Provider Identifier (NPI), the associated provider must be enrolled with KMAP and have a valid NPI on file for the claim to be considered for payment. Reference Section 2000 of the *General Benefits Fee-for-Service Provider Manual*.

FL 1 **Required.** Enter the name, address, and telephone number of the billing provider.

FL 2 This field is not used by Kansas Medicaid.

FL 3a **PAT. CNTL #**
Enter the beneficiary's account number, if desired. This number will be referenced on the RA.

FL 3b **MED. REC. #**
Enter the beneficiary's medical record number. (This number will appear on the RA.)

FL 4 **TYPE OF BILL**
Required. Enter the three-digit number specific to the type of claim.
Note: Only the codes in bold below are applicable to NFs.

Medicaid allowed codes:

- 1st digit indicates facility.
 - **1 Hospital (IP/OP)**
 - **2 Skilled nursing**
 - **6 Intermediate care**
 - 8 Outpatient – Critical Access
- 2nd digit indicates location within facility.
 - 1 Inpatient
 - 3 Outpatient
 - **5 Level I**
 - **6 Level II**
 - 8 Swing bed NF
- 3rd digit indicates the frequency of the claim billed.
 - 0 Nonpayment/zero claim
 - 1 Admit through discharge claim
 - 2 Interim - first claim
 - 3 Interim - continuing claim
 - 4 Interim - last claim (thru date is discharge date)

FL 5 **FED. TAX NO.**
Required. Enter the federal tax number.

FL 6 **STATEMENT COVERS PERIOD**
Required. Enter the span of service dates included in the particular bill. The “FROM” date is the earliest date of service on the bill.

FL 7 This field is not used by Kansas Medicaid.

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FL 8 PATIENT NAME

Required. Enter the beneficiary's last name, first name, and middle initial exactly as it appears on the KMAP ID card. If patient is a newborn, enter "newborn", "baby boy", or "baby girl" in the first name field and enter the mother's last name.

FL 9 PATIENT ADDRESS

Required. Enter the full address of the beneficiary.

- a – Street address
- b – City
- c – State
- d – ZIP code
- e – Plus 4

FL 10 BIRTHDATE

Required. Enter beneficiary's date of birth in MM/DD/YYYY format. If newborn, enter baby's date of birth (not mother's).

FL 11 SEX

Required. Enter "M" for male or "F" for female. If newborn, enter "M" or "F" to indicate the baby's sex.

FL 12 ADMISSION DATE

Required. Enter the date the patient was admitted as an inpatient to the facility (or indicate the start of care date for home health and hospice). It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill.

FL 13 ADMISSION HOUR

Required – inpatient only. Enter treatment hour using the continental time system (6:00 p.m. equals 1800 hours).

FL 14 ADMISSION TYPE

Required – hospital inpatient only. Enter a one-digit code to indicate type of admission.

- | | | |
|---------------|--------------|-------------------------------|
| 1 – Emergency | 3 – Elective | 5 – Trauma |
| 2 – Urgent | 4 – Newborn | 9 – Information not available |

FL 15 ADMISSION SRC

Required on all claims except 014X. Enter a one-digit code to indicate admission source. Reference the *Official UB-04 Data Specifications Manual* for valid values.

FL 16 DHR

The discharge hour is required on inpatient claims with a frequency code of 1, 4 or 7 except type of bill 021X.

FL 17 STATUS

Required - inpatient only. Enter a two-digit code to indicate the status of the beneficiary. Reference the *Official UB-04 Data Specifications Manual* for valid values.

Note: Hospitals will be eligible for full DRG reimbursement when a discharge occurs using discharge code 01, 03, 04, 05, 06, 07, 08, 20, 50, or 51. Distinct claim forms must be submitted for each discharge.

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In the case of transfers to same specialty providers (discharge code 02), the transferring hospital's reimbursement may be reduced, based upon a transfer prorated reimbursement determination, and the **receiving** hospital will be eligible to receive a full DRG reimbursement.

FL 18-28 **CONDITION CODES**

Enter a two-digit code to indicate a condition(s) relating to inpatient or outpatient claims, special programs, or procedures (e.g. KAN Be Healthy, sterilization).
Reference the *Official UB-04 Data Specifications Manual* for valid values.

FL 29 **ACCIDENT STATE**

Required, if applicable.

Enter the two-digit state abbreviation code where the accident occurred.

FL 30 This field is not used by Kansas Medicaid.

FL 31-34 **OCCURRENCE**

Required when an occurrence code applies to the claim.

Occurrence codes can only be submitted on Line a.

Occurrence codes must be indicated if reporting information on type of accident, crime victim, other insurance denial or date of third-party liability (TPL) termination, or aborted surgery, false labor or nondelivery claim where associated services are indicated.

All Kansas Department for Children and Families (DCF) guidelines remain the same regarding attachments required for TPR proof and SSA/Medicare EOMBs.

Reference the *Official UB-04 Data Specifications Manual* for valid values.

FL 35-36 **OCCURRENCE SPAN**

Required when an occurrence code is used.

Enter occurrence span code(s) and from and through date(s).

FL 37 This field is not used by Kansas Medicaid.

FL 38 This field is not used by Kansas Medicaid.

FL 39-41 **VALUE CODES**

Required, if applicable.

Enter the appropriate two-digit value code and applicable amount.

Reference the *Official UB-04 Data Specifications Manual* for valid values.

- Under CODE, enter D3 for nonpatient obligation. Under AMOUNT, enter the nonpatient obligation dollar amount. Examples of nonpatient obligation are Parental, Spousal, and Trust.
- Under CODE, enter 80 for covered days. Under AMOUNT, enter the number of covered days.

Note: Count the date of admission but not the date of discharge.

FL 42 **REV. CD.**

Required – inpatient only.

Enter the three-digit revenue code identifying the type of accommodation and ancillary service(s). **DO NOT INDICATE REVENUE CODE(S) IF THE SERVICE IS NONCOVERED.**

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Note: Revenue codes are not to be indicated for outpatient services.
Inpatient emergency renal dialysis must be billed using revenue code 809.

For nursing facilities, use only the following revenue codes.

- 101 All inclusive room and board
- 120 Room-board/semi
- 180 NF/MH inpatient psychiatric hospital stay (21-day limit per admission)
- 181 NF/MH home therapeutic reserve days (21 days per calendar year)
Note: Use this code for services on or before July 31, 2013.
- 183 NF/MH home therapeutic reserve days (21 days per calendar year)
Note: Use this code for services on or after August 1, 2013.
- 183 NF home therapeutic reserve days (18 days per calendar year)
- 185 NF hospital reserve days (10-day limit per admission)
- 189 Noncovered days

FL 43 REVENUE DESCRIPTION/IDE NUMBER/MEDICAID DRUG REBATE

If billing a service with a NDC, include all of the required information in this field. The N4 qualifier must be present before the NDC number, followed by the unit/basis of measurement and number of units.

Example: N412345678901UN1234.567

The following qualifiers are accepted for the NDC unit/basis of measurement:

- F2 – International Unit
- GR – Gram
- ME – Milligram
- ML – Milliliter
- UN – Unit

Additional information is available on the [NUBC](#) website.

FL 44 HCPCS / RATE / HIPPS CODE

Required – outpatient only. List the HCPCS procedure code for each specific outpatient procedure. **Do not indicate procedure(s) if the service is noncovered.**

FL 45 SERV. DATE

Required – outpatient only. Enter the date services were provided in MM/DD/YY format.

FL 46 SERV. UNITS

Required. Enter the number of days for each accommodation revenue code or appropriate units for each outpatient service billed.

FL 47 TOTAL CHARGES

Required.

- Enter total charges for each coded line item. List each outpatient procedure with a specific (itemized) charge. **DO NOT INDICATE CHARGES FOR NONCOVERED SERVICES.**
- Enter the total claim charge on the last line of this detail section with a revenue code of 001 in FL 42 and total charges in FL 47.

FL 48 NON-COVERED CHARGES

Situational. Enter noncovered charges.

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FL 49 This field is not used by Kansas Medicaid.

FL 50 **PAYER NAME**

Required. Enter all third-party resources.

Line A – Use to indicate primary payer name.

Line B – Use to indicate secondary payer name.

Line C – Use to indicate tertiary payer name.

Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.

FL 51 **HEALTH PLAN ID**

If other payers are involved in potentially paying the claim, enter the ID number used to identify the payer.

Line A – *Required*

Line B & C – *Situational*

Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance must be included with the submission of the claim.

FL 52 **REL. INFO**

Required. Enter the release of information certification locator.

FL 53 **ASG. BEN.**

Required. This code indicates the provider has signed a form authorizing the third-party payer to remit payment directly to the provider.

Valid values:

N – No

W – Not applicable (Use when patient refuses to assign benefits.)

Y – Yes

FL 54 **PRIOR PAYMENTS**

Required if other insurance is involved. Report the other insurance payment amount. If there has not been a payment made by the other insurance, report 0.00.

When a Medicare Part B payment has been made on an Inpatient claim, indicate the amount paid as prior payment.

Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance must be included with the submission of the claim.

Line A – Use to indicate primary payment.

Line B – Use to indicate secondary payment.

Line C – Use to indicate tertiary payment.

FL 55 **Est. Amount Due**

Situational. Enter the estimated amount due (estimated responsibility less prior payments).

Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance must be included with the submission of the claim.

Line A – Primary

Line B – Secondary

Line C – Tertiary

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- FL 56** **NPI**
Required. Enter the billing provider's NPI.
- FL 57** **OTHER PRV ID**
Only required when an NPI is not used in FL 56 and an identification number other than the NPI is necessary to identify the provider or to report other provider identifiers as assigned by the health plan (as indicated in FL 50 Lines A-C) as required.
- FL 58** **INSURED'S NAME**
Required. Enter the insured's name.
Line A – Primary
Line B – Secondary
Line C – Tertiary
- FL 59** **PATIENT'S RELATIONSHIP TO INSURED**
Enter the code to indicate the relationship of the patient to the identified insured.
Line A – *Required*
Line B & C – *Situational*
- | Code | Description |
|------|--------------------|
| 01 | Spouse |
| 18 | Self |
| 19 | Child |
| 20 | Employee |
| 21 | Unknown |
| 39 | Organ donor |
| 40 | Cadaver donor |
| 53 | Life partner |
| G8 | Other relationship |
- FL 59a** **PRIMARY PAYER**
- FL 59b** **SECONDARY PAYER**
- FL 59c** **TERTIARY PAYER**
- FL 60** **INSURED'S UNIQUE ID**
Required. Enter the 11-digit Medicaid beneficiary number from the patient's medical ID card on Line C. If newborn services, use the mother's Medicaid beneficiary number if the newborn's ID number is unknown.

Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance must be included with the submission of the claim.
Line A – Primary insurance beneficiary ID
Line B – Secondary insurance beneficiary ID
Line C – Tertiary insurance beneficiary ID
- FL 61** **INSURED'S GROUP NAME**
Required. The group or plan name through which the insurance is provided to the insured. Enter the insured's group name if it is available and FL 62 is not used.

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Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance must be included with the submission of the claim.

Line A – Primary

Line B – Secondary

Line C – Tertiary

FL 62 INSURANCE GROUP NO.

Required. Enter the insurance group number when the insured's ID card shows a group number.

Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance must be included with the submission of the claim.

Line A – Primary

Line B – Secondary

Line C – Tertiary

FL 63 AUTHORIZATION CODE/REFERRAL NUMBER

Not required. Identifier designating the services on the bill have been authorized or a referral is involved by the payer or utilization management organization (UMO).

FL 63a AUTHORIZATION CODE

Not required.

FL 63b REFERRAL NUMBER

Not required.

FL 63c SECONDARY PAYER AUTHORIZATION CODE

Not required.

FL 64 DOCUMENT CONTROL NUMBER

Required. Enter the document control number assigned to the original bill by the health plan or the health plan's fiscal agent. *Required* when the TOB frequency code (FL 04) indicates this claim is a replacement or void to a previously adjudicated claim.

Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance must be included with the submission of the claim.

Line A – Primary

Line B – Secondary

Line C – Tertiary

FL 65 INSURED'S EMPLOYER NAME

Situational. Enter the employer name of the insured.

Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance must be included with the submission of the claim.

Line A – Primary

Line B – Secondary

Line C – Tertiary

FL 66 DIAGNOSIS AND PROCEDURE CODE QUALIFIER

Required. Enter qualifier code 9 for ICD-9 diagnoses or 0 for ICD-10 diagnoses, as appropriate.

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- FL 67** **PRINCIPAL DIAGNOSIS AND PRESENT ON ADMISSION INDICATOR**
Required. Enter the principal diagnosis code and present on admission indicator. Follow the official coding guidelines for ICD reporting. POA requirements for ECI, refer to FL 72.
Outpatient emergency renal dialysis must be billed using the following diagnosis codes: O084, T795XXA, N170, N171, N172, N178, N179, O0382, O0482, O0732, O904.
- FL 67 A-Q** **OTHER DIAGNOSIS AND PRESENT ON ADMISSION INDICATOR**
Required. Enter the other diagnoses code(s) when other conditions coexist or develop during the patient's treatment and enter the present on admission (POA) indicator(s) when other diagnoses are included.
Note: The POA code must be typed on the paper claim form. If handwritten, the code may not be recognized.
- FL 68** This field is not used by Kansas Medicaid.
- FL 69** **ADMIT DX**
Required on 012X, 022X, and Inpatient claims, except 028X, 065X, and 066X.
Admitting diagnosis is required when the claim involves an inpatient admission.
- FL 70** **PATIENT REASON FOR VISIT**
Not required. Enter the ICD diagnosis code appropriate to the ICD revision indicated in FL 66 which describes the patient's stated reason for the visit at the time of outpatient registration. No POA is required for outpatient claim forms. Follow the official coding guidelines for ICD reporting.
- FL 71** **PPS CODE**
Enter the prospective payment system code.
- FL 72 A-C** **ECI**
Situational: Enter the external cause of injury code when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during medical treatment. Chapter 20 ICD-10-CM codes are POA exempt. See FL 67.
Note: For ICD-9 "E" diagnosis codes, do not submit a POA indicator.
Note: The POA code must be typed on the paper claim form. If handwritten, the code may not be recognized.
- FL 73** This field is not used by Kansas Medicaid.
- FL 74** **PRINCIPAL PROCEDURE CODE AND DATE**
Required for inpatient hospital claims, if applicable. Enter the ICD procedure code for the primary procedure and date of service for inpatient claims.
- FL 74 A-E** **OTHER PROCEDURE CODES AND DATES**
Required for hospital inpatient claims, if applicable. Enter the other procedure(s) performed, using ICD procedure code(s) and date of service.
- FL 75** This field is not used by Kansas Medicaid.

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FL 76

ATTENDING

Required. Do not enter a group provider number.

NPI – Enter the provider’s National Provider Identifier.

QUAL – Enter qualifier G2 (KMAP provider ID) or PXC (taxonomy). Enter the KMAP provider ID or taxonomy code in the space to the right of QUAL.

LAST – Enter the provider’s last name.

FIRST – Enter the provider’s first name.

FL 77

OPERATING

Required, if applicable.

NPI – Enter the provider’s National Provider Identifier.

QUAL – Enter qualifier G2 (KMAP provider ID) or PXC (taxonomy). Enter the KMAP provider ID or taxonomy code in the space to the right of QUAL.

LAST – Enter the provider’s last name.

FIRST – Enter the provider’s first name.

FL 78-79

OTHER

Required, if applicable.

NPI – Enter the provider’s National Provider Identifier.

QUAL – Enter qualifier G2 (KMAP provider ID) or PXC (taxonomy). Enter the KMAP provider ID or taxonomy code in the space to the right of QUAL.

LAST – Enter the provider’s last name.

FIRST – Enter the provider’s first name.

Note: If the claim is for sterilization, the surgeon performing the sterilization procedure must be identified by their KMAP provider ID in FL 78.

FL 80

REMARKS

Specify additional information as necessary.

When billing medically necessary incoming transfers, the following should be entered on claims for incoming transfers from other hospitals: “Direct transfer from (hospital, city)”.

FL 81

CODE-CODE FIELD

Enter additional codes related to field locator overflow or to report externally maintained codes approved by the NUBC.

LEFT COLUMN – Qualifier

MIDDLE COLUMN – Code

RIGHT COLUMN – Number or value

Examples:

A1 – Condition code

A1	44	
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A2 – Occurrence code

A2	01	022806
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A3 Occurrence span code

A3	M4	030106030906
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B3 – Taxonomy code (used for the billing provider only)

B3	XXXN00000X	
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