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## **SECTION 15-BILLING INSTRUCTIONS**

This section has detailed instructions for completing the billing claim form for inpatient and outpatient services. In an effort to make this section as instructive for billing purposes as possible, we have presented information on a number of specific services. Some of these subjects have been discussed as policy issues in other sections of this manual and are cross-referenced.

Similar to the format used in Section 13, Section 15 has been arranged by subjects common to both inpatient and outpatient services and then into the subjects specific to inpatient and outpatient billing information.

### **Information Common to Inpatient and Outpatient Billing**

#### **15.1 ELECTRONIC DATA INTERCHANGE**

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12N Implementation Guides, adopted under HIPAA, at [www.wpc-edi.com](http://www.wpc-edi.com). For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the X12N Version 4010A1 and NCPDP Telecommunication V.5.1 & Batch Transaction Standard V.1.1 Companion Guides found through this web site. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals
- X12N Version 4010A1 or NCPDP Telecommunication V.5.1 & Batch Transaction Standard V.1.1 Companion Guide.

#### **15.2 INTERNET ELECTRONIC CLAIM SUBMISSION**

Providers may submit claims via the Internet. The web site address is [www.emomed.com](http://www.emomed.com). Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference <http://dss.missouri.gov/mhd/> and click on the Apply for Internet Access link. Providers are unable to access [www.emomed.com](http://www.emomed.com) without proper authorization. An authorization is required for each individual user.

For full functionality of the Internet application, either the Internet Explorer 5.0 or higher web browser or the Netscape 4.7 or higher web browser is recommended. The features of the Internet application include claim submissions, claim credits and eligibility verification.

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

### **15.3 UB-04 CLAIM FORM**

The UB-04 claim form is always used to bill MO HealthNet for inpatient and outpatient hospital services unless a provider bills those services electronically. Instructions on how to complete the UB-04 claim form are on the following pages.

### **15.4 PROVIDER RELATIONS COMMUNICATION UNIT**

It is the responsibility of the Provider Relations Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of this manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Infocrossing Healthcare Services Help Desk at (573) 635-3559.

### **15.5 RESUBMISSION OF CLAIMS**

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. The provider may resubmit electronically or on an UB-04 claim form. An example of a correctable error is the use of an invalid procedure code. A claim that has denied appropriately for failing timely filing should *not* be resubmitted.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, a claim indicates 2 units instead of 3. If everything else on the claim was correct, the provider is paid the maximum amount allowed for 2 units. That claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider *must* submit an Individual Adjustment Request. Section 6 of this manual explains the adjustment request process.



### 15.6 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET

When a participant has both Medicare and MO HealthNet coverage, a claim *must* be filed with Medicare first as primary payor. If the patient has Medicare but the service is *not* covered or the limits of coverage have been reached previously, a paper claim *must* be submitted to MO HealthNet with the Medicare Remittance Advice attached indicating the denial. Reference Section 16.5 of this manual for instructions for submission of claims to MO HealthNet when services are *not* covered by Medicare.

If a claim was submitted to Medicare indicating that the participant also had MO HealthNet and disposition of the claim is *not* received from MO HealthNet within 60 days of the Medicare remittance advice date (a reasonable period for transmission for Medicare and MO HealthNet processing), you must submit the crossover claim to MO HealthNet on line at [www.emomed.com](http://www.emomed.com). Reference Section 16 for billing instructions.

### 15.7 MAILING ADDRESSES

Infocrossing Healthcare Services  
P.O. Box (see below)  
Jefferson City, MO 65102

- Inpatient Claims .....Box 5100
- Outpatient Claims .....Box 5200
- Prior Authorization Requests .....Box 5700
- Medicare/MO HealthNet Crossovers Hard Copy Claims.....Box 5600
- CMS-1500 Claims .....Box 5600
- Claim Attachment Submissions *not* Submitted with Claims .....Box 5900  
(Refer to Section 23.1)

The following address *must* be used if a provider is sending claims by an express delivery service:

Infocrossing Healthcare Services  
905 Weathered Rock Road  
Jefferson City, MO 65101



## 15.8 BILLING PROCEDURES FOR SERVICES EXEMPT FROM THE COST SHARING REQUIREMENT

### 15.8.A INPATIENT

For emergency inpatient admissions, the claim should show admit code “1” in Field #14, admission type. Therapies are *not* an exemption for inpatient services.

### 15.8.B OUTPATIENT

To properly identify on the outpatient claim services that are exempt from cost sharing, the following condition codes *must* be used:

- Emergency Services..... Condition Code AJ (Admission Type 1)
- Exempted Therapies (physical therapy, chemotherapy, radiation therapy, and chronic renal dialysis) ..... Condition Code AJ
- Family Planning Services ..... Condition Code A4

When emergency or family planning services are provided in an outpatient setting, only one date of service may be shown on the claim. Claims are denied if multiple dates are shown with a condition code AJ and admission type 1 for emergency services or condition code A4 for family planning services.

When billing MO HealthNet, indicate the usual and customary charge for the service as the billed amount in the charge column. Do *not* deduct the participant’s cost sharing amount from the billed charge and do *not* show it as an amount paid or as another source payment. The claims processing system calculates the maximum allowable fee and automatically deducts the cost sharing amount, thus determining the correct payable amount.

## 15.9 OBSTETRICAL CARE

It is important to use a diagnosis code that is appropriate for a pregnancy-related service as distinguished from one that is appropriate for a delivery. A claim for prenatal care *must* indicate a diagnosis for pregnancy. There are many ICD-9-CM diagnosis codes for pregnancy depending on possible complications. For a normal uterine pregnancy without complications, the diagnosis code is V22. Refer to the ICD-9-CM for codes indicating a specific problem or complication.

If a delivery is performed, the diagnosis code on the claim *must* be one of the codes listed in ICD-9-CM under “Delivery”. Do *not* use a pregnancy diagnosis code when a delivery has been performed.

## 15.10 BILLING FOR TEMP ELIGIBLE PARTICIPANTS

It is important to view a TEMP card or a TEMP letter each time services are rendered to pregnant women. Reference Section 1.5.J for information on TEMP participants.

Providers may bill immediately for ambulatory prenatal services rendered on the basis of the TEMP card.

A pregnancy/prenatal diagnosis is required on the claim form (V22 through V23.9 or V28 through V28.9) in one of the diagnosis fields.

### 15.10.A INPATIENT HOSPITAL SERVICES

Inpatient hospital services are *not* considered “ambulatory prenatal services;” therefore, inpatient hospital claims billed for participants with only TEMP eligibility are denied.

A TEMP participant may apply for full MO HealthNet coverage and be determined eligible for the complete range of MO HealthNet covered services. Regular MO HealthNet coverage may be backdated and may overlap a TEMP eligibility period. Approved individuals receive an approval letter that shows their eligibility dates and type of assistance coverage. Services that are *not* covered under the TEMP Program may be resubmitted under the new type of assistance using the participant’s MO HealthNet Identification Number instead of the TEMP number. The resubmitted claims are then processed without TEMP restrictions.

An individual who has been TEMP eligible may be determined eligible for full MO HealthNet benefits; however, the eligibility period may *not* always go back to the beginning date of TEMP eligibility. In this situation a participant may be TEMP eligible for a portion of an inpatient hospitalization stay and also eligible for regular MO HealthNet for a portion of the hospital stay. The hospital *must* only bill as covered days those dates for which the participant was eligible for regular MO HealthNet. If the hospital bills the entire stay as covered days, the claim denies. Hospital providers of inpatient hospital services should show all TEMP only days as noncovered days. Field #6, “From date” of service on the UB-04 claim form, should show the first date of regular MO HealthNet eligibility during the hospital stay. This is the first “covered” day of the hospital stay. If a provider is uncertain as to the dates of the participant’s regular MO HealthNet coverage, they may call Program Relations at (573) 751-2896 to verify this information. The admission date in Field #17 on the UB-04 claim form *must* reflect the actual date the admission occurred.

## 15.11 THIRD PARTY LIABILITY (TPL)

Federal and state regulations require that insurance benefits be utilized as the first source of payment for medical expenses incurred by MO HealthNet participants. Section 5 of this manual explains TPL in detail, including how to determine if a participant has other health benefits.

Providers *must* bill any health insurance resource a participant has before billing MO HealthNet. All third party resource benefits received by the provider for MO HealthNet covered services *must* be shown on the MO HealthNet claim in Field #54.

Federal regulation 42 CFR 447.20 states, “A provider may *not* refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan based on a third party’s potential liability for the service.”

### 15.11.A TPL EDIT

In the processing of claims the TPL edit compares a claim to the participant’s eligibility file for third party resources. If the eligibility file indicates there is applicable insurance coverage but there is no TPL amount shown on the claim or no attachment showing denial of payment by the insurance company, the claim denies. If an insurance carrier denies payment, a copy of that denial letter *must* be submitted with the claim. Enter in Field #80, Remarks, that insurance denied the claim and that a copy of the denial letter is attached.

If the provider believes the insurance coverage shown on the MO HealthNet Division’s participant file is incorrect, the MO HealthNet Insurance Resource Report (TPL-4) should be completed to report this. An explanation of this form is given in Section 5. The TPL-4 *must not* be submitted with claims. Send the form to the address shown on the form.

Type of insurance coverage codes identified on on the interactive voice response (IVR) system, a point of service (POS) terminal, or eligibility files accessed via the Internet are listed in Section 5, Third Party Liability.

While providers are verifying the patient’s eligibility, they can obtain the TPL information contained on the MO HealthNet Division’s participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 635-8908, which allows the provider to inquire on third party resources. The provider may also use a point of service (POS) terminal or the Internet at [www.emomed.com](http://www.emomed.com) to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 for more information.

Participants *must* always be asked if they have third party insurance regardless of the TPL information given by the IVR, POS terminal or Internet. IT IS THE PROVIDER’S



RESPONSIBILITY TO OBTAIN FROM THE PARTICIPANT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5 of this manual, Third Party Liability.

### 15.11.B TPL BYPASS

Claims that involve prenatal care, preventive pediatric care, and claims for which the TPL is derived from a parent, whose obligation for medical support is being enforced by the Family Support Division, bypass the TPL Edit.

Providers have the choice for these services of billing the other insurance first or billing directly to MO HealthNet.

If a provider who has provided one of the above categories of service elects *not* to pursue the TPL resource, the claim should be submitted to the fiscal agent for payment. The MO HealthNet agency then pursues recovery from the TPL resource. The provider *must* state on the claim form whether or not the TPL resource has been billed. Please include the insurance resource name and address in the statement. This should appear in Fields #50, Payer, and #61, Insured Group Name, on the UB-04. State in Field #80 of the UB-04 form whether the insurance has been billed.

Claims for delivery or for newborn care are *not* included in the TPL bypass. TPL, if applicable, *must* be billed first for those services.

The guidelines for prenatal and preventive pediatric care claims that bypass the TPL edit are as follows:

#### Prenatal Care

PRIMARY diagnosis codes that exempt a claim from TPL denial:

1. V22-V23.9
2. V28-V28.9
3. 640-648.9 range with fifth digit 3
4. 651-658.9 range with fifth digit 3
5. 671-671.9 range with fifth digit 3
6. 673-673.8 range with fifth digit 3
7. 675-676.9 range with fifth digit 3

#### Preventive Pediatric Care—Participants Under Age 21

PRIMARY diagnosis codes that exempt a claim from TPL denial.

1. V01-V07.9
2. V20-V20.2
3. V70.0
4. V72.0-V72.3
5. V73-V75.9
6. V77.0-V77.7
7. V78.2-V78.3
8. V79.2-V79.3
9. V79.8
- 10.V82.3-V82.4
- 11.EPS

## **15.12 BILLING FOR INPATIENT SERVICES THAT FOLLOW OUTPATIENT SERVICES**

### **15.12.A OUTPATIENT SURGERY**

When admission is necessary following outpatient surgery, the surgery and related services *must* be billed on the outpatient claim. No surgery procedure can be shown on the inpatient claim. Information given to HCE for admission certification *must* be clear that surgery was performed prior to admission. If a second surgery is performed following admission, that surgery code is entered on the inpatient claim.

### **15.12.B OBSERVATION ROOM**

When admission is necessary following observation, the date of admission on the inpatient claim *must* be the date the hospital formally admits the patient. Services provided in the observation room may be billed on an outpatient claim.

## **15.13 BILLING FOR PHYSICIAN AND CRNA SERVICES**

Services of hospital-salaried or contractually compensated physicians and CRNAs may be billed by hospital providers on the CMS-1500 claim form. In order for a hospital to bill for physician or CRNA services, providers are offered three billing alternatives. The billing method chosen should be a mutually agreed upon choice by the physicians, CRNAs and the facility. Refer to Section 13.49.

## 15.14 ADMISSION CERTIFICATION INFORMATION

A detailed explanation of the policy on admission certification is given in Section 13.31. The following information is provided to assist in the proper completion of the claim form. The admission certification contains critical information a provider *must* enter on the claim in order to satisfy the claims processing edits for admission certification.

After HCE approves an admission, a letter is sent to both the hospital and the attending physician. The letter confirms the information previously given by either telephone, fax or a written request. It is important that the information in this letter be verified for accuracy. It is suggested that a copy of the HCE letter be given to the billing department for comparison with the information on the claim that is submitted to MO HealthNet. If any information on the HCE approval letter is different from the hospital's records, HCE *must* be contacted so the fiscal agent's claims processing file can be updated.

The information given in the review process is sent by HCE to the fiscal agent's claims processing file. The data entered on the UB-04 discussed below *must* match the HCE file or payment is *not* made.

### 15.14.A TREATMENT AUTHORIZATION CODE—FIELD #63

This field is a *required field* for all claims except those for Medicare Part A, certain pregnancy-related conditions, newborns and deliveries. For approved admissions HCE gives providers a unique seven-digit certification number. Enter this number in Field #63.

### 15.14.B ADMISSION DATE—FIELD #12

This field is a *required field*. The admission date on the UB-04 *must* match the admission date on the HCE file or the claim denies. If the HCE reviewer approves an inpatient service but denies a preoperative or weekend day, the provider may still admit for preoperative or weekend but that day(s) is *not* paid by MO HealthNet. In this situation the provider can receive payment for covered days by entering the first day HCE approves for coverage as the "from date" in Field #6, Statement Covers Period.

**Example:** The provider plans to admit a patient on Tuesday for surgery on Friday. HCE approves the surgery but says admission should be Thursday for Friday surgery. If the provider admits the patient on Tuesday, enter that date in Field #12, Admissions, and enter Thursday's date in Field #6 as the "from" day. This will "match" the HCE file and the claim can be reimbursed. In this situation the inpatient preoperative days are *not* payable by MO HealthNet as the days were denied by HCE.

#### **15.14.C PRINCIPAL PROCEDURE—FIELD #80**

This is *not* a required field for MO HealthNet but may be important for payment if surgery is applicable to the hospitalization. This only applies if the CPT procedure code is in the range 10040-69979. If the information given by the provider in the request for admission certification includes a date of surgery, this information is entered in the HCE file. Therefore, the claim is edited to have that identical date. We realize changes in scheduling do occur, especially with surgery, or when the preadmission request is two weeks ahead of the planned date. If an admission is certified with surgery anticipated but *not* performed or the date of surgery changes, then HCE *must* be contacted with updated information.

If an admission is certified with no surgery indicated at the time of request, it is *not* required to contact HCE if a surgery is performed during the inpatient stay.

NOTE: If HCE denies a provider's request for admission certification after the patient has formally been admitted, charges for those inpatient services *cannot* be billed on an outpatient claim. Claims are monitored postpayment to ensure compliance with this policy.

#### **15.15 CERTIFICATION OF ALCOHOL AND SUBSTANCE ABUSE DETOXIFICATION**

Inpatient limitation for alcohol and drug detoxification is explained in Section 13.39. The letters that HCE sends hospital providers, physicians and participants for certification of detoxification stays show the first certified date ("From" date on claim) through the last certified date ("Through" date on claim). The last certified date, usually the day of discharge, is a nonpayable day.

If a continued stay is requested and approved, a second letter is sent by HCE with an updated "through" date.

#### **15.16 DIAGNOSES ON THE INPATIENT CLAIM**

Providers should code the first diagnosis, Field #67 of the UB-04, on the basis of the principal diagnosis. This is the diagnosis that, after study, explains why the patient was admitted to the hospital. The principal diagnosis is the condition chiefly responsible for the admission even though another diagnosis may be more severe.

If a diagnosis code that is considered invalid in the ICD-9-CM is used in the primary field, a claim denies. However, if an invalid diagnosis code is shown in the secondary field, the code is changed to "zeros" in processing the claim. This prevents a claim from denying, but it can result in reducing the number of PAS days a secondary diagnosis allows for inpatient days exempt from HCE certification.

A hospital *must not* use as either a primary or secondary diagnosis an ICD-9-CM diagnosis code in the range 780-799, “Symptoms, Signs, and Ill-defined Conditions” or “Other Ill-defined and Unknown Causes of Morbidity and Mortality,” when a more definitive diagnosis or indication has been established and entered on the medical record discharge summary.

Two examples of incorrect billing:

Primary diagnosis description	Cholelithiasis
Primary diagnosis code	574.20
Secondary diagnosis description	Abdominal Pain
Secondary diagnosis code	789.00
Primary diagnosis description	Myocardial Infarction
Primary diagnosis code	410
Secondary diagnosis description	Chest Pain
Secondary diagnosis code	786.5

In these examples, abdominal pain and chest pain (symptoms) *must not* be shown on the claim because a more definitive diagnosis has been established.

It is also incorrect billing practice to use primary and secondary diagnoses that are in the same range, for example, diagnosis 37331, eczematous dermatitis of eyelid, and 37332, contact and allergic dermatitis of eyelid.

### 15.17 ACCOMMODATION REVENUE CODE

An accommodation revenue code is required on an inpatient claim. Refer to the Inpatient Hospital Revenue Codes listing. Accommodation codes are those numbered from 110 to 219. Ancillary codes are those from 250 to 949.

An ancillary code, for example 720, Delivery/Labor Room, can *never* be considered an accommodation code even if the provider shows a rate and number of units (days). A claim denies if no valid, covered accommodation code is shown.

The number of covered days in code 80 and noncovered days code 81 in fields 39-41 of the claim form *must* equal the number of units in field #46 for valid accommodation codes.

It is important that the revenue code used corresponds with the diagnosis code on the claim. For example, a diagnosis code of 308, Acute reaction to stress, should be billed with a revenue code of 114, Psychiatric. A diagnosis code of 541, Appendicitis, should be billed with a revenue code of 121, Medical/Surgical/Gyn. More than one revenue code may be used to reflect multiple accommodations.

## 15.18 INTERIM BILLING

It is usually *not* appropriate to submit more than one claim for one continuous hospitalization. A patient should be discharged from the hospital before a claim is submitted to the fiscal agent. A “Patient Status” code 30, which means “Still a patient,” in Field #17 of the claim form, should only be used in a very limited number of circumstances, such as the following:

1. The patient becomes ineligible for MO HealthNet benefits during the stay.
2. The hospital’s utilization review committee does *not* certify as medically necessary all days of the stay.
3. The allowable number of days is unusually long and in order to ease the cash flow, the provider interim bills.
4. The claim is for days prior to the date of an authorized transplant.

If a provider does bill a second (or third) claim for the same hospitalization period, the certification information in Field #63 should be the same as the first claim. The claims processing system suspends interim billed claims to determine the correct number of allowed days under PAS. Interim billed claims representing one continuous stay that exceed the PAS allowed number of days or HCE approved days are cut back to the allowed days. The EOB messages in those situations are EOB 717, “Claim cutback due to interim claim exceeding approved or allowed days” or EOB 718, “Our records indicate maximum allowable PAS days paid for this hospitalization.” Reference Section 13.30.

## 15.19 PRORATING TPL (THIRD PARTY LIABILITY)

Insurance benefits to which a participant is entitled *must* be utilized as the first source of payment for hospital and medical expenses. Third party liability is discussed in Section 5. When it has been established that the number of inpatient hospital days reimbursed by a third party insurer exceeds the number of MO HealthNet allowed days, the TPL amount needs to be prorated. It is the provider’s responsibility to determine when this method of billing is necessary.

Field #54, Prior Payments, should be completed as follows:

Field #54—If the private insurance company payment includes days that are in excess of PAS or HCE approved days (nonreimbursable days or other noncovered services), prorate the reimbursement to coincide with the number of days MO HealthNet pays per PAS or HCE limitations.

**Example:** The total number of days of confinement on claim is 15 days and PAS/HCE limitation allows 10 days (5 days nonreimbursable by MO HealthNet). The private insurance payment amount

is \$10,000.00 for 15 days of confinement. The prorated insurance amount is \$666.67 (\$10,000.00 / 15) per day x 10 days (PAS) = \$6,666.70. The amount of \$6,666.70 *must* be entered in field #54.

The provider may wish to show in Field #80, Remarks, the calculation of the prorated TPL in order to substantiate the dollar amount entered in Field #54.

**15.20 SURGICAL PROCEDURE—FIELD #67**

This is to clarify situations in which Fields #67, Principal Procedure Code and Date, and #67 A-D, Other Procedure Codes and Dates, are to be completed on the inpatient claim form.

If it is necessary to use the operating room to perform a procedure, then the principal procedure Field #67 on the claim should be completed. If more than one procedure was performed, identify and date any others in Field #67 A-D using CPT-Surgical Procedure Codes.

If a procedure is performed in the patient’s room, in a treatment room, or in another area of the hospital that is *not* an operating room, do *not* complete the surgical procedure code fields of the claim form.

If a procedure is entered in this field, there *must* be a revenue code shown for operating or labor/delivery room. A claims processing edit monitors for compliance.

ICD-9-CM procedure code 96.49 (other genitourinary instillation) is restricted by MO HealthNet and requires a Certificate of Medical Necessity for Abortion. Procedural Cross Coder: Essential Links from ICD-9-CM Volume 3 Procedural Codes to CPT Codes (Ingenex 2004 Edition) crosswalks ICD-9 procedure code 96.49 to procedure codes for abortion as well as some that are *not* abortion related. If possible, non-abortion related CPT codes *must* be crosswalked to ICD-9-CM procedure codes that are *not* restricted. If ICD-9 procedure code 96.49 is most appropriate for the procedure performed and is unrelated to an elective abortion, submit medical documentation which reflects fetal demise prior to the procedure being performed.

**15.21 MO HEALTHNET UB-04 INPATIENT HOSPITAL CLAIM FILING INSTRUCTIONS**

NOTE: An asterisk (\*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (\*\*) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
*1. Provider Name, Address, Telephone Number	Enter the provider name and address exactly as it appears on the provider label. For



convenience, affix the provider label issued by the fiscal agent. This preprinted label contains all required information. When affixing the label, do *not* cover other fields. Claim forms may be ordered from the fiscal agent with this required information preprinted on the form.

- 2. Unlabeled Field  
Leave blank.
- 3a. Patient Control Number  
For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
- 3b. Med Rec #  
Leave blank.
- \*4. Type of Bill  
The required three digits in this code identify the following:
  - 1st digit: type of facility
  - 2nd digit: bill classification
  - 3rd digit: frequencyThe allowed values for each of the digits found in the type of bill are listed below:  
Type of Facility: 1st digit:
  - (1) HospitalBill Classification: 2nd digit:
  - (1) Inpatient (Including Medicare Part A)
  - (2) Inpatient (Medicare Part B only)Frequency: 3rd digit
  - (1) Admit thru Discharge Claim
  - (2) Interim Bill—First Claim
  - (3) Interim Bill—Continuing Claim
  - (4) Interim Bill—Last Claim
- 5. Federal Tax Number  
Enter the provider's federal tax number.
- \*6. Statement Covers Period  
(from and through dates)  
Indicate the beginning and ending dates being billed on this claim form.  
Enter in MMDDYY or MMDDYYYY numeric format.



- It *should* include the discharge date as the through date when billing for the entire stay. Unless noted below, it *should* include all days of the hospitalization.
- It *should not* include date(s) of patient ineligibility. It *should not* include inpatient days that were *not* certified by HCE, such as preop days or days beyond the cease payment date.
7. Unlabeled Field Leave blank.
- 8a. Patient's Name - ID Enter the patient's 8-digit MO HealthNet DCN or MO HealthNet Managed Care Plan identification number.
- NOTE: The MO HealthNet DCN or MO HealthNet Managed Care Plan identification number is *required* in Field #60.
- \*8b. Patient Name Enter the patient's name in the following format: last name, first name, middle initial.
9. Patient Address Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, state and zip code.
10. Patient Birth Date Enter the patient's date of birth in MMDDYY format.
11. Patient Sex Enter the patient's sex, "M" (male) or "F" (female).
- \*12. Admission Date Enter in MMDDYY format the date that the patient was admitted for inpatient care. This should be the actual date of admission regardless of the patient's eligibility status on that date or HCE certification/denial of the admission date.
13. Admission Hour Leave blank.
- \*14. Admission Type Enter the appropriate type of admission; the allowed values are:

- 1—Emergency
- 2—Urgent
- 3—Elective
- 4—Newborn

\*\*15. Source of Admission (SRC) If this is a transfer admission, complete this field. The allowed values are:

- 1— Physician Referral
- 2— Clinic 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
- 9— Information Not Available
- A—Transfer from a Critical Access Hospital
- B—Transfer from Another Home Health Agency
- C—Readmission to Same Home Health Agency
- D—Transfer from Hospital Inpatient in the Same Facility Resulting in a Seperate Claim to Payer

16. Discharge Hour

Leave blank.

\*17. Patient Status

Enter the 2-digit patient status code that best describes the patient's discharge status

Common values are:

- 01—Discharged to home or self-care
- 02—Discharged/transferred to another short-term general hospital for inpatient care
- 03—Discharged/transferred to skilled nursing facility
- 04—Discharged/transferred to an intermediate care facility
- 05—Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to

- another institution
- 06—Discharged/transferred to home under care of organized home health service
- 07—Left against medical advice, or discontinued care
- 08—Discharged/transferred to home under care of Home IV provider
- 20—Expired
- 30—Still a patient
- 63—Discharged/transferred to a Medicare certified long-term care hospital (LTCH)

\*18-24. Condition Codes

Enter the appropriate two-character condition code(s). The values applicable to MO HealthNet are:

- C1—Approved as billed  
Indicates the facility's Utilization Review authority has certified all days billed.
- C3—Partial Approval  
The stay being billed on this claim has been approved by the UR as appropriate; however, some portion of the days billed have been denied. *If C3 is entered, Field #35 must be completed.*

*NOTE: CODE C1 OR C3 IS REQUIRED.*

- A1—Healthy Children & Youth/EPSDT  
If this hospital stay is a result of an HCY referral or is an HCY related stay, this condition code *must* be entered on the claim.
- A4—Family Planning  
If family planning services occurred during the inpatient stay, this condition code *must* be entered.

25-28. Condition Codes

Leave blank.

29. Accident State

Leave blank.

30. Unlabeled field	Leave blank.
**31-34. Occurrence Code and Date	<p>If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim:</p> <p>01—Auto Accident                  02—No Fault Insurance                  03—Accident/Tort Liability                  04—Accident/Employment Related                  05—Other Accident                  06—Crime Victim                  42—To be entered when “through” date in Field #6 (Statement Covers Period) is <i>not</i> equal to the discharge date and the frequency code in Field #4 indicates that this is the final bill.</p>
**35. Occurrence Span Codes and Dates (from and through)	<p>Required if C3 is entered in Fields #18-24. Enter code “MO” and the first and last days that were approved by Utilization Review.</p>
36. Occurrence Span Codes and Dates	Leave blank.
37. Unlabeled field	Leave blank.
38. Responsible Party Name and Address	Leave blank.
*39-41. Value Codes and Amounts	<p>Enter the appropriate code(s) and unit amount(s) to identify the information necessary for the processing of the claim.</p> <p>80—Covered Days</p> <p>Enter the number of days shown in field #6, minus the date of discharge. The discharge date is <i>not</i> a covered day and should <i>not</i> be included in the calculation of this field.</p> <p>The through date of service in field #6 is included in the covered days, if the patient status code in Field #17 is equal to "30—still a patient."</p>

NOTE: The units entered in this field *must* be equal to the number of days in "Statement Covers Period", less day of discharge. If patient status is "still a patient," units entered include through day.

81—Noncovered Days

If applicable, enter the number of noncovered days. Examples of noncovered days are those days for which the patient is ineligible.

NOTE: The total units entered in this field *must* be equal to the total accommodation units listed in field #46.

\*42. Revenue Code

List appropriate accommodation codes first in chronological order.

Ancillary codes should be shown in numerical order.

Show duplicate revenue codes for accommodations when the rate differs or when transfers are made back and forth, e.g., general to ICU to general.

A private room *must* be medically necessary and the medical need *must* be documented in the patient's medical records unless the hospital has only private rooms. The private room rate times the number of days is entered as the charge.

If the patient requested a private room, which is noncovered, multiply the private room rate by the number of days for the total charge in Field #47. Enter the difference between the private room total charge and the semiprivate room total charge in field #48, noncovered charges.

After all revenue codes are shown, skip a line and list revenue code 001, which

- represents total charges.
43. Revenue Description Leave blank.
- \*44. HCPCS/Rates/HIPPS Code Enter the daily room and board rate to coincide with accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use a separate line to report each rate.
45. Service Date Leave blank.
- \*46. Service Units Enter the number of units for the accommodation line(s) only. This field should show the total number of days hospitalized, including covered and noncovered days.
- NOTE: The number of units in Field #39-#41 *must* equal the number of units in this field.
- \*47. Total Charges Enter the total charge for each revenue code listed. When all charge(s) are listed, skip one line and state the total of these charges to correspond with revenue code 001.
- NOTE: The room rate multiplied by the number of units *must* equal the charge entered for room accommodation(s).
- \*\*48. Non-covered Charges Enter any noncovered charges. This includes all charges incurred during those noncovered days entered in fields #39-#41. If Medicare Part B was billed, those Part B charges should be shown as noncovered.
- The difference in charges for private versus non-private room accommodations when the private room was *not* medically necessary should be shown as non-covered in this field.
49. Unlabeled Field Leave blank.
- \*50. Payer Name The primary payer is always listed first. If the patient has insurance, the insurance plan

	is the primary payer and “MO HealthNet” is listed last.
51. Health Plan ID	Leave blank.
52. Release of Information Certification Indicator	Leave blank.
53. Assignment of Benefits Certification of Indicator	Leave blank.
**54. Prior Payments	Enter the amount the hospital received toward payment of this bill from all other health insurance companies. Payments <i>must</i> correspond with the appropriate payer entered in Field #50. (See Note)(1)  Do <i>not</i> enter a previous MO HealthNet payment, Medicare payment or copay amount received from the patient in this field
55. Estimated Amount Due	Leave blank.
56. National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI number
*57. Other Provider ID	Enter the hospitals 9-digit MO HealthNet legacy provider number.
**58. Insured's Name	Complete if the insured's name is different from the patient's name. (See Note)(1)
59. Patient's Relationship to Insured	Leave blank.
*60. Insured's Unique ID	Enter the patient's 8-digit MO HealthNet or MO HealthNet Managed Care Plan identification number. If insurance was indicated in Field #50, enter the insurance number to correspond to the order shown in Field #50.
**61. Insurance Group Name	If insurance is shown in Field #50, state the name of the group or plan through which the insurance is provided to the insured. (See Note)(1)
**62. Insurance Group Number	If insurance is shown in Field #50, state the

	number assigned by the insurance company to identify the group under which the individual is covered. (See Note)(1)
**63. Treatment Authorization Codes	For claims requiring certification, enter the unique 7-digit certification number supplied by HCE.
**64. Document Control Number	If the current claim exceeds the timely filing limit of one year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one-year limit.
65. Employer Name	If the patient is employed, the employer's name may be entered here.
66. Diagnosis & Procedure Code Qualifier	Leave blank.
*67. Principal Diagnosis Code	Enter the ICD-9-CM diagnosis code for the condition established after study to be chiefly responsible for the admission.  Remember to code to the highest level of specificity shown in the current version of the ICD-9-CM diagnosis code book.
**67. A- Other Diagnosis Codes D	Enter any additional diagnosis codes that have an effect on the treatment received or the length of stay.
67. E-Q Other Diagnosis Codes	Leave blank.
68. Unlabeled Field	Leave blank
69. Admitting Diagnosis	Leave blank.
70. Patient's Reason for Visit	Leave blank.
71. Prospective Payment system (PPS) Code	Leave blank.
72. External Cause of Injury Code (E Code)	Leave blank.



- |   |  |
|---|--|
| 73. Unlabeled Field                           | Leave blank.   |
| **74. Principal Procedure Code and Date       | Enter the full ICD-9-CM procedure code of the principal surgical procedure. The date on which the procedure was performed <i>must</i> be shown. Only month and day are required.   |
| **74. A-E Other Procedure Codes and Dates     | Identify and date any other procedures that may have been performed.   |
| 75. Unlabeled field                           | Leave blank.   |
| *76. Attending Provider Name and Identifiers  | <p>Physician's NPI is optional</p> <p>Enter the attending physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number.</p> <p>The appropriate qualifiers are:<br/>                     OB - State License Number<br/>                     1G - Provider UPIN Number<br/>                     G2 - MO HealthNet Legacy Provider Number</p>  |
| **77. Operating Provider Name and Identifiers | <p>Physician's NPI is optional.</p> <p>Enter the operating physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number.</p> <p>The appropriate qualifiers are:<br/>                     OB - State License Number<br/>                     1G - Provider UPIN Number<br/>                     G2 - MO HealthNet Legacy Provider Number</p> |
| **78-79. Other Provider Name and Identifiers  | <p>Physician's NPI is optional.</p> <p>Enter the physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number.</p>  |

The appropriate qualifiers are:

OB - State License Number

1G - Provider UPIN Number

G2 - MO HealthNet Legacy Provider Number

\*\*80. Remarks

Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.

81CC. Code-Code Field

Enter the taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field # 56.

The appropriate qualifier is:

B3—Healthcare Provider Taxonomy code.

\* These fields are mandatory on *all* Inpatient UB-04 claim forms.

\*\* These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information **only**. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.

## 15.22 COVERED REVENUE CODES

(Transplant facilities *must* refer to Transplant Manual for billing transplant revenue codes.)

## 15.23 OUTPATIENT FACILITY CHARGE

A facility charge may be shown on the outpatient claim when the hospital provides services to a person who is registered on the hospital records as an outpatient. Services *must* have been provided by a MO HealthNet enrolled physician, nurse practitioner or podiatrist.

If the following services are the *only* services provided during a visit, without any physician services, a facility charge *must not be shown*:

- Physical, occupational or speech therapy
- Renal dialysis
- Injections/immunizations

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- Laboratory/pathology
- Radiology
- HCY/EPSTD services

These services can be billed by the hospital using the appropriate HCPCS Level I (CPT), Level II or Level III procedure code.

The facility charge should include the following hospital operational cost elements:

- Administrative costs
- Basic floor stock supplies
- Durable, reusable items or medical equipment other than diagnostic, testing or treatment equipment
- Fixed building costs
- Furnishings
- Insurance
- Laundry
- Maintenance
- Nursing salaries
- Paramedical salaries
- Records maintenance
- Utilities

Services performed by hospital staff that are incidental to physician services *must not* be separately itemized and added to the facility charge. Included in a facility charge are such services as venipuncture, specimen collection, taking and monitoring vital signs, prepping, positioning, injecting, and routine monitoring (e.g., fetal, cardiac, etc.).

The costs of diagnostic testing and treatment type equipment as well as the costs of hospital staff who are necessary to the performance of a specific diagnostic or therapeutic procedure should be included in the charge for that service. Examples of this are radiology procedures, renal dialysis, and physical therapy.

Only one facility code may be shown per date of service. If several physicians or clinics are seen, the charges *must* be combined into one facility code.

A charge for an observation service is *not* considered a facility charge. Therefore, as an example, a provider can show a surgery facility code and an observation code for the same date of service.

## 15.24 OUTPATIENT FACILITY AND SUPPLY CODES

### 15.24.A FACILITY CODES

Only one facility revenue code may be billed per date of service.

0450	Emergency; nonsurgical
0459	Emergency; surgical
0490	Outpatient clinical; surgical
0510	Outpatient clinical; nonsurgical

### 15.24.B OUTPATIENT SUPPLY CODES

Each code may be billed once per date of service. Multiple charges for the same supply revenue code must be combined into one charge.

0250	"General Classification: Pharmacy" for all medications
0260	I.V. supplies
*0270	Medical/Surgical supplies
0274	Orthopedic supplies
0390	Blood

\* Revenue code 270 should be reported only once on an outpatient claim. It is to be reported for medical or surgical supplies or both combined.

## 15.25 OUTPATIENT SUPPLY CHARGES

Supply charges *must not* include services performed by hospital staff. This policy includes such services as venipuncture, specimen collection, taking vitals, monitoring services, prepping, positioning, etc.

Supplies that can be billed on the claim form should be those that are consumed or disposed of after using for one patient. Basic floor stock supplies are included in the facility charge and should *not* be shown in the supply charge.

Items that are durable and reusable such as furniture, instruments, equipment, IV stands/pumps, IVAC regulators and reusable control service supplies *must not* be included in a supply charge. Their costs should be reflected in an ancillary or facility charge.

## **15.26 OUTPATIENT OBSERVATION SERVICES**

Observation service charges may be shown separately on an outpatient claim. Listed below is the revenue code that represents the number of hours in an observation room. If the provider has a patient in an observation room more than 24 hours, the charges beyond that time *must* be absorbed as an expense to the provider. Those charges *cannot* be billed to MO HealthNet or to the participant. If the patient stays past midnight, the date of service is the date the patient came in. Only one observation code per stay may be billed.

Charges for diagnostic and procedural services that occur after the initial 24 hours has expired may be billed to Mo HealthNet.

### **15.26.A OUTPATIENT OBSERVATION CODES**

<b>Revenue Code</b>	<b>Quantity</b>	<b>Description</b>
0762.....	1 .....	Observation Room, 1 to 5 hours
0762.....	2 .....	Observation Room, 6 to 11 hours
0762.....	3 .....	Observation Room, 12 to 17 hours
0762.....	4 .....	Observation Room, 18 to 24 hours

There are circumstances in which a facility charge may be shown on a claim in addition to the observation room charge. An example of that is when emergency room services or operating room services are provided in addition to observation.

## **15.27 OUTPATIENT MEDICATIONS**

Revenue code 0250, "General Classification: Pharmacy" is used to indicate all medication provided during an outpatient clinic/emergency room visit.

When multiple kinds of medication are administered during the visit, they should be billed under one revenue code 0250. The code should be listed with a quantity of one and and reflect the total charge of all medications provided.

NOTE: Only drugs and items used at the hospital are covered services. Take-home medications and supplies are *not* covered by MO HealthNet in the Hospital Program. These items may be billed to the participant. The participant should be made aware by the provider that take-home medications may be reimbursable by MO HealthNet when a prescription is filled by an enrolled pharmacy provider.

In situations where a patient is seen during the night and a pharmacy will *not* be open until morning to dispense a prescription, it is permissible to send one or two tablets of an oral medication with the patient. The billing of this is subject to close scrutiny by the MO HealthNet Program Integrity Unit.

**15.28 IMMUNIZATIONS**

Through the Vaccine for Children (VFC) Program, federally provided vaccines are available at no cost to public and private providers for eligible children ages 0 through 18 years of age. Children that meet at least one of the following criteria are eligible for VFC vaccine:

- MO HEALTHNET ENROLLED—means a child enrolled in the MO HealthNet Program
- UNINSURED—means a child has no health insurance coverage
- NATIVE AMERICAN/ALASKAN NATIVE—means those children as defined in the Indian Health Services Act
- UNDERINSURED—means the child has some type of health insurance, but the benefit plan does *not* include vaccinations. The child *must* be vaccinated in a Federally Qualified Health Clinic (FQHC) or a Rural Health Clinic (RHC).

MO HealthNet enrolled providers *must* participate in the VFC Program administered by the Missouri Department of Health and Senior Services and *must* use the free vaccine when administering vaccine to qualified MO HealthNet eligible children. For more information regard the specific guidelines of the VFC Program contact the following:

Department of Health and Senior Services  
 Section of Vaccine-Preventable & Tuberculosis Disease  
 Elimination  
 PO Box 570  
 Jefferson City, MO 65109  
 (800) 219-3224 or (573) 526-5833

For adult (over 19 years of age) immunizations the appropriate CPT code should be used.

**15.29 MO HEALTHNET UB-04 OUTPATIENT HOSPITAL CLAIM FILING INSTRUCTIONS**

NOTE: An asterisk (\*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (\*\*) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
---------------------	-----------------------------

- \*1. Provider Name, Address, Telephone Number  
Enter the provider name and address exactly as it appears on the provider label. For convenience, affix the provider label issued by the fiscal agent. This preprinted label contains all required information. When affixing the label, do *not* cover other fields. Claim forms may be ordered from the fiscal agent with this required information preprinted on the form.
- 2. Unlabeled Field  
Leave blank.
- 3a. Patient Control Number  
For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
- 3b. Med Rec #  
Leave blank.
- \*4. Type of Bill  
The required three digits in this code identify the following:
  - 1st digit: type of facility
  - 2nd digit: bill classification
  - 3rd digit: frequencyThe valid type of bill is "131."
- 5. Federal Tax Number  
Enter the providers federal tax number or leave blank.
- 6. Statement Covers Period (from and through dates)  
Indicate the beginning and ending dates being billed on this claim form.
- 7. Unlabeled Field  
Leave blank.
- 8a. Patient's Name - ID  
Enter the patient's 8-digit MO HealthNet DCN or MO HealthNet Managed Care Plan identification number.  
  
NOTE: The MO HealthNet DCN or MO HealthNet Managed Care Plan identification number is *required* in Field #60.
- \*8b. Patient Name  
Enter the patient's name in the following format: last name, first name, middle initial.
- 9. Patient Address  
Enter the patient's full mailing address,

	including street number and name, post office box number or RFD, city, state and zip code.
10. Patient Birth Date	Enter the patient's date of birth in MMDDYY format.
11. Patient Sex	Enter the patient's sex, "M" (male) or "F" (female).
12. Admission Date	Leave blank.
13. Admission Hour	Leave blank.
**14. Admission Type	Leave blank unless this claim is for an emergency room service. If so, enter Admission Type '1.' Condition code AJ also <i>must</i> be listed in Field #24 to exempt the patient from the \$3.00 cost sharing amount for the service.
15. Source of Admission (SRC)	Leave blank.
16. Discharge Hour	Leave blank.
17. Patient Status	Leave blank.
**18-24. Condition Codes	Enter the applicable two-character condition code. The values are:  A1—HCY/EPST  If this service is the result of an HCY referral or is an HCY related visit, enter this condition code.  A4—Family Planning.  If the family planning service occurred during the visit, enter this condition code. Do <i>not</i> bill family planning services on the same claim as non-family planning services.  AJ—Payer Not Responsible for Co-Payment  If visit is the result of an emergency or therapy services are provided, then condition code <i>must</i> be entered to exempt the patient from the \$3.00 cost sharing amount.



25-28. Condition Codes	Leave blank.
29. Accident State	Leave blank.
30. Unlabeled field	Leave blank.
**31-34. Occurrence Code and Date	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim:  01—Auto Accident 02—No Fault 03—Accident/Tort Liability 04—Accident/Employment Related 05—Other Accident 06—Crime Victim
35-36. Occurrence Span Codes and Dates	Leave blank.
37. Unlabeled field	Leave blank.
38. Responsible Party Name and Address	Leave blank.
39-41. Value Code and Amounts	Leave blank.
*42. Revenue Code	If billing for a facility charge, an observation room charge, cardiac rehabilitation, supplies and/or on-site medications, enter only the appropriate 4-digit revenue code(s) for the hospital's outpatient facility charge(s).
43. Revenue Description	Leave blank.
*44. HCPCS/Rates/HIPPS Code	Enter the CPT or HCPCS procedure code(s) and any applicable modifier.  Only enter the procedure code if for services <i>other</i> than outpatient facility charges listed in Field #42.
*45. Service Date	Enter the date of service on each line billed in MMDDYY format.
*46. Service Units	Enter the number of units for each procedure, or revenue code.  <b>NOTE:</b> If no entry is made, the system

autoplugs a unit of "1". Facility codes 0450, 0459, 0490 and 0510 and supply codes 0260, 0270 and 0274 should always be billed with a unit of "1." The outpatient observation code 0762 should be billed with the appropriate unit quantity of "1," "2," "3" or "4."

- \*47. Total Charges Enter the total charge for each line item. After all charges are listed, skip a line and enter the total of all charges for this claim to correspond to revenue code 0001.
- 48. Noncovered Charges Leave blank.
- 49. Unlabeled Field Leave blank.
- \*50. Payer Name The primary payer is always listed first. If the patient has insurance, the insurance plan is the primary payer and "MO HealthNet" is listed last.
- 51. Health Plan ID Leave blank.
- 52. Release of Information Certification Indicator Leave blank.
- 53. Assignment of Benefits Certification of Indicator Leave blank.
- \*\*54. Prior Payments Indicate the amount the provider received toward payment of this bill from all other health insurance companies. Payments *must* correspond with the appropriate payer entered in Field #50. (See Note)(1)  
  
Do *not* enter a previous MO HealthNet payment, Medicare payment or copay amount received from the patient in this field
- 55. Estimated Amount Due Leave blank.
- 56. National Provider Identifier (NPI) Enter the hospital's 10-digit NPI number
- \*57. Other Provider ID Enter the hospitals 9-digit MO HealthNet legacy provider number.

- |  |   |
|--|---|
| **58. Insured's Name                     | Complete if the insured's name is different from the patient's name. (See Note)(1)  |
| 59. Patient's Relationship to Insured    | Leave blank.  |
| *60. Insured's Unique ID                 | Enter the patient's 8-digit MO HealthNet or MO HealthNet Managed Care Plan identification number. If insurance was indicated in Field #50, enter the insurance number to correspond to the order shown in Field #50.  |
| **61. Insurance Group Name               | If insurance is shown in Field #50, state the name of the group or plan through which the insurance is provided to the insured. (See Note)(1)   |
| **62. Insurance Group Number             | If insurance is shown in Field #50, state the number assigned by the insurance company to identify the group under which the individual is covered. (See Note)(1)   |
| 63. Treatment Authorization Codes        | Leave blank.  |
| **64. Document Control Number            | If the current claim exceeds the timely filing limit of one year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one-year limit. |
| 65. Employer Name                        | If the patient is employed, the employer's name may be entered here.  |
| 66. Diagnosis & Procedure Code Qualifier | Leave blank.  |
| *67. Principal Diagnosis Code            | Enter the complete ICD-9-CM diagnosis code for the condition the service was provided.  |

	Remember to code to the highest level of specificity shown in the current version of the ICD-9-CM diagnosis code book.
**67. A- Other Diagnosis Codes D	Enter any additional diagnoses for which treatment was given.
67. E-Q Other Diagnoses Codes	Leave blank.
68. Unlabeled Field	Leave blank
69. Admitting Diagnosis	Leave blank.
70. Patient's Reason for Visit	Leave blank.
71. Prospective Payment system (PPS) Code	Leave blank.
72. External Cause of Injury Code (E-Code)	Leave blank.
73. Unlabeled Field	Leave blank.
**74. Principal Procedure Code and Date	Enter the full CPT surgical procedure code. The date on which the procedure was performed <i>must</i> be stated. Only month and day are required.
**74. A-E Other Procedure Codes and Dates	If more than one procedure was performed, enter the appropriate CPT surgical procedure code(s) and the date the procedure(s) was (were) performed. Only the month and day are required.
75. Unlabeled field	Leave blank.
**76. Attending Provider Name and Identifiers	Physician's NPI is optional  Enter the attending physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number.  The appropriate qualifiers are:  OB - State License Number 1G - Provider UPIN Number G2 - MO HealthNet Legacy Provider

	Number
77. Operating Provider Name and Identifiers	<p>Physician's NPI is optional.</p> <p>Enter the operating physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number.</p> <p>The appropriate qualifiers are:</p> <p>OB - State License Number 1G - Provider UPIN Number G2 - MO HealthNet Legacy Provider Number</p>
**78.79. Other Provider Name and Identifiers	<p>Physician's NPI is optional.</p> <p>Enter the physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number.</p> <p>The appropriate qualifiers are:</p> <p>OB - State License Number 1G - Provider UPIN Number G2 - MO HealthNet Legacy Provider Number</p> <p>If the participant's services are restricted due to administrative lock-in, enter the lock-in physician's number in this field and attach the Medical Referral Form of Restricted Participant (PI-118).</p>
80.. Remarks	<p>Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.</p>
81CC. Code-Code Field	<p>Enter the taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field # 56.</p>

The appropriate qualifier is:

B3—Healthcare Provider Taxonomy code.

\* These fields are mandatory on *all* Outpatient UB-04 claim forms.

\*\* These fields are mandatory only in specific situations, as described.

**(1)** NOTE: This field is for private insurance information **only**. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.

**END OF SECTION**

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