

UB-04 CMS-1450 Paper Claim Form Revisions

The following table includes the required and optional fields that were revised for the new UB-04 CMS-1450 claim form. All other required fields on the UB-04 CMS-1450 claim form are unchanged, as outlined in the 2007 *Texas Medicaid Provider Procedures Manual (TMPPM)*, Section 5.6.4, "HCFA-1450 (UB-92) Instruction Table," on page 5-34, and in the 2007 *CSHCN Services Program Provider Manual Part I*, Section B.3, "Instructions for Completing the HCFA-1450 (UB-92) Claim Form," on page B-7.

Field	Description	Guidelines
2	Unlabeled	Optional No guidelines for this field.
3a	Patient control number	Optional Any alphanumeric character (limit 16) entered in this field will be referenced on the Remittance and Status (R&S) report.
3b	Medical record number	Enter the client's medical record number (limited to ten digits) assigned by the hospital.
4	Type of bill (TOB) Most commonly used: 0111 Inpatient hospital 0131 Outpatient hospital 0141 Nonpatient (laboratory or radiology charges) 0331 Home health agency* 0711 Rural health clinic (RHC) 0721 Renal dialysis center (RDC) 0731 Federally qualified health center (FQHC) * Use TOB 331 only. All other TOBs are invalid and will deny.	This field has been expanded from 3 to 4 characters with a 0 always as the first digit. Claims will be processed based on the last three digits. Enter the three-digit TOB code. <i>First digit – type of facility</i> 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (RHC, FQHC, RDC) 8 Special facility <i>Second digit – bill classification (except clinics and special facilities)</i> 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7 Intermediate care <i>Second digit– bill classification (clinics only)</i> 1 Rural health 2 Hospital-based or independent RDC 3 Free standing 5 Comprehensive outpatient rehabilitation facility (CORF) <i>Third digit – frequency</i> 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim–first claim 3 Interim–continuing claim 4 Interim–last claim 5 Late charges–only claim 6 Adjustment of prior claim 7 Replacement of prior claim

Field	Description	Guidelines
7	Unlabeled	Optional No guidelines for this field.
8a	Patient identifier	Optional Enter the patient identification number if different than the subscriber/insured's identification number.
8b	Patient name	Enter the client's last name, first name, and middle initial as printed on the Medicaid Identification Form.
9a-9b	Patient address	Starting in 9a, enter the client's complete address as described (street, city, state, and ZIP code).
10	Birth date	Enter the month, day, and year (MM/DD/YYYY) the client was born.
11	Sex	Indicate the client's sex by entering an "M" or "F."
12	Admission date	Enter the date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; start of care (SOC) for home health claims. Note: Providers that receive a transfer patient from another hospital must enter the original admission date to identify the payer.
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This field is not required for nonpatients (TOB 141), home health claims (TOB 331), RHCs (TOB 711), RDCs (TOB 721), or FQHCs (TOB 731).
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Field 15.) 5 Trauma center

Field	Description	Guidelines
15	Source of admission	<p>Enter the appropriate source of admission code for inpatient claims.</p> <p><i>For type of admission 1, 2, or 3</i></p> <ul style="list-style-type: none"> 1 Physician referral 2 Clinic referral 3 Health maintenance organization (HMO) referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information not available <p><i>For type of admission 4 (newborn)</i></p> <ul style="list-style-type: none"> 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
16	Discharge hour	<p>For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the field blank. Code 99 is not acceptable.</p>

Field	Description	Guidelines
17	Patient status	<p>For inpatient claims, enter the appropriate two-digit code to indicate the client's status as of the statement "through" date.</p> <p>01 Routine discharge 02 Discharged to another short-term general hospital 03 Discharged to skilled nursing facility (SNF) 04 Discharged to intermediate care facility (ICF) 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on diagnosis-related group [DRG]) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired – place unknown (hospice use only) 43 Federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice – home 51 Hospice – medical facility 61 Medicare – approved swing bed 62 Inpatient rehabilitation facility (IRF), including rehabilitation distinct part of a hospital 63 Long term care hospital (LTCH) 64 Medicaid-only nursing facility 65 Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)</p> <p><i>Additional patient status codes for CSHCN Services Program providers</i></p> <p>71 Discharged to another institution of outpatient (OP) services 72 Discharged to another institution</p>
18-28	Condition codes	Enter the two-digit condition code "05" and date (MM/DD/YYYY) the legal claim was filed for recovery of funds potentially due a client as a result of legal action initiated by or on behalf of the client if this condition is applicable to the claim.
29	ACDT state	Optional Accident state.
30	Unlabeled	Optional No guidelines for this field.
31-34	Occurrence codes and dates	Enter the appropriate code(s) and date(s). Medicaid-required codes are found in the 2007 TMPPM, Section 5.6.5, "Occurrence Codes" on page 5-41, and in the 2007 <i>CSHCN Services Program Provider's Manual Part I</i> , Section B.3.1 "Occurrence Codes" on page B-14. Fields 54, 61, 62, and 80 must also be completed as required.

Field	Description	Guidelines
35-36	Occurrence span codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.
39-41	Value codes	<p>Accident hour – For inpatient claims, if the client was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown.</p> <p>For inpatient claims, enter value code 80 with the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances the number in this field will be equal to the number of covered accommodation days listed in field 46.</p> <p>For inpatient claims, enter value code 81 with the total days represented on this claim that are not covered. The sum of fields 39 – 41 must equal the total days billed as reflected in Field 6.</p>
45 (line 23)	Creation date	Enter the date the bill was submitted.
57	Other identification (ID) number	Enter the Texas Provider Identifier (TPI) number (nonNational Provider Identifier (NPI) number) of the billing provider.
67	Principal diagnosis (DX) code and present on admission (POA) indicator	<p>Enter the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available.</p> <p>Optional POA Indicator – Enter the applicable POA indicator in the shaded area for inpatient claims.</p>
67A-67Q	Other DX codes and POA indicator	<p>Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per field.</p> <p>A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141").</p> <p>Exception: A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alpha-fetoprotein.</p> <p>Note: ICD-9-CM diagnosis codes entered in 67I – 67Q are not required for systematic claims processing.</p> <p>Optional POA indicator – Enter the applicable POA indicator in the shaded area for inpatient claims.</p>
68	Unlabeled	Optional No guidelines for this field

Field	Description	Guidelines
69	Admit DX code	Enter the ICD-9-CM diagnosis code indicating the cause of admission or include narrative. Note: <i>The admitting diagnosis is only for inpatient claims.</i>
70a – 70c	Patient reason DX	Optional New field indicating the client's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	Optional The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a – 72c	External cause of injury (ECI) and POA indicator	Optional Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. POA indicator – Enter the applicable POA indicator in the shaded area for inpatient claims.
73	Unlabeled	Optional No guidelines for this field.
74	Principal procedure code and date	Enter the ICD-9-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
74a – 74e	Other procedure codes and dates	Enter the ICD-9-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
76	Attending provider	Attending provider name and identifiers; For inpatient claims, enter the physician's license number or Universal Provider Identification Number (UPIN) of the provider who performed the service/procedure and/or is responsible for the treatment and plan of care in the following format: 11233333 1 Two-digit state indicator (for example, TX for Texas) 2 Licensing board indicator examples B = Doctor of medicine (MD) or doctor of osteopathy (DO) D = Dentist P = Podiatrist C = Chiropractor 3 License number (Example: TXBL1234) If the provider has a temporary license number, enter "TEMPO." (Example: TXBTEMPO) Procedures are defined as those listed in the ICD-9-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures. For outpatient claims, enter the license number of the physician referring the patient to the hospital. <i>TPI must be entered in field to the right of qualifier box, if applicable</i>

Field	Description	Guidelines
77	Operating provider	<p>Enter operating provider name and identifiers. This is required when a surgical procedure code is listed on the claim. Include the name and ID number of the individual with the primary responsibility for performing the surgical procedure(s).</p> <p><i>TPI must be entered in field to the right of qualifier box, if applicable</i></p>
78-79	Other (a or b) provider	<p>Other provider name and identifiers:</p> <p>For outpatient claims, enter the license number for the following:</p> <ul style="list-style-type: none"> • The ordering physician for all laboratory and radiology services. (If a different physician ordered laboratory or radiology services, enter his/her license number in field 76, and enter the referring/attending physician's license number or UPIN in this field.) • The designated physician for a limited client when the physician performed or authorized nonemergency care. • Referring provider – The provider who sent the patient to another provider for services. Required on an outpatient claim when the referring provider is different than the attending physician. <p>Note: <i>If the referring physician is a resident, fields 76 and 78 must identify the physician who is supervising the resident.</i></p> <p>Other operating physician – An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved.</p> <p>Rendering provider – The health care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure.</p> <p><i>TPI must be entered in field to the right of qualifier box, if applicable.</i></p>

Field	Description	Guidelines
FL80	Remarks	<p>This field is used to explain special situations such as the following:</p> <ul style="list-style-type: none"> • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this field. • If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated and signed by the physician. • If services are the result of an accident the cause and location of the accident must be entered in this field. The time must be entered in Field 39. • If laboratory work is sent out, the name and address or the Medicaid provider identifier of the facility where the work was forwarded must be entered in this field. • If the patient is deceased, enter the date of death. • If services were rendered on the date of death, enter the time of death. • If the services resulted from a family planning provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address of the facility where the services were rendered. • Enter the date of onset for patients receiving dialysis services. • Request for 110-day rule for a third-party insurance.
81a – 81d	Code code (CC)	<p>Optional</p> <p>Area to capture additional information necessary to adjudicate the claim. Required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere on the claim data set.</p>

The following table describes fields that have been deleted from the new UB-04 CMS-1450 claim form and are no longer required for claims processing. Field numbers listed on the following table correspond to the fields in the original UB-92 HCFA 1450 claim form:

Field	Description
66	Employer location
79	Procedure coding method
85	Provider signature
86	Date bill submitted

Details about the UB-04 CMS-1450 claim form and instructions for paper billers will also be available in the May/June 2007 *Texas Medicaid Bulletin*, No. 204, and the *May 2007 CSHCN Bulletin* No. 62.

Information about electronic billing changes are available in the revised EDI Companion Guides located on the TMHP website. Please refer to the upcoming *National Provider Identifier (NPI) Special Bulletin*, No. 205, for additional information regarding electronic billing and TDHconnect.

For changes relating to National Provider Identifier (NPI) implementation, refer to the *National Provider Identifier (NPI) Special Bulletin*, No. 202 and the upcoming *National Provider Identifier (NPI) Special Bulletin*, No. 205.

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Contact Center at 1-800-568-2413.