

**Field Requirements for CMS-1450 Claims Forms (UB94)
For Driscoll Children's Health Plan**

| Field | Description | Required/Optional | Remarks |
|--------------|---|--------------------------|--|
| 1 | Billing Provider Information NOTE: This is the physical address of the location where services were provided. This is not a Post Office Box address. | Required | <u>Four-lines of information:</u> Name Address City/State/Zip Phone: 123-123-1234 |
| 2 | Pay-To Provider Information NOTE: A PO Box is acceptable in this space. | Situational | Required if the pay-to provider address is different than the billing provider. |
| 3a | Patient Control Number | Optional | Enter your patient account number, if provided this number will be returned on the EOB/EOP. |
| 3b | Medical/Health Record Number | Optional | May be used for the patient's medical record number. This field is not reported back on the EOB/EOP. |
| 4 | Bill Type | Required | Use NUBC taxonomy tables for acceptable values NOTE: This field plays a role in the adjudication of the claim. An incorrect value in this field could result in an incorrect payment. |
| 5 | Federal Tax ID | Required | Enter number WITHOUT hyphen: <u>NNNNNNNNN</u> NOTE: Forms are scanned into electronic files; a hyphen may result in payment inaccuracy or rejection of your claim. |
| 6 | Statement Covers From and Thru Dates FORMAT: <u>MMDDYY</u> without dashes, slashes or spaces. | Required | Outpatient = enter the first and last dates of services billed on this claim. Inpatient = enter admit and discharge date for this admission. If interim billing is being performed, enter the first and last dates of the services that are being billed on the form. |
| 7 | Unassigned | Not Used | |
| 8a | Patient ID# | Required | Enter patient's DCHP ID#: STAR : 9 numeric characters CHIP : 9 alpha-numeric characters with alpha |

Required = Mandatory

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| | | | character appearing in the lead position. |
| 8b | Patient Name | Required | Patient name: Last, First Middle Sample: SMITH, MARY JO |
| 9a | Patient Address | Required | Patient's street address |
| 9b | Patient City | Required | Patient's city |
| 9c | Patient State | Required | Patient's state – 2-digit USPO abbreviation required |
| 9d | Patient Zip Code | Required | Patient's zip code – 5 digits are required. 9-digit is optional. If 9-digit is used DO NOT use a hyphen. |
| 9e | Patient County Code | Optional | If used, must use codes provided by American National Standards Institute in ISO3166 |
| 10 | Date of Birth | Required | Enter date: MMDDYYYY without hyphens, slashes or spaces |
| 11 | Sex | Required | M = male F = female U = unknown |
| 12 | Admission or Start of Care Date | Required on both inpatient and outpatient claims | Enter date: MMDDYY without hyphens, slashes or spaces |
| 13 | Admission Hour | Required | Use NUBC taxonomy tables for acceptable values: 00 through 23 to define the hour |
| 14 | Admission Type | Required on Inpatient Optional on Outpatient | 1 = emergency 2 = urgent 3 = elective 4 = newborn 5 = trauma 9 = information not available |
| 15 | Admission Source | Required | Use NUBC taxonomy tables for acceptable values |
| 16 | Discharge Hour | Required on inpatient where bill type end is a 1, 2, 3, or 4. Optional on outpatient | Use NUBC taxonomy tables for acceptable values: 00 through 23 to define the hour |
| 17 | Discharge Status | Required on inpatient Not Used on outpatient | Use NUBC taxonomy tables for acceptable values |
| 18-28 | Condition Codes | Situational, but required where the condition code | Use NUBC taxonomy tables for acceptable values |

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| | | applies to the bill | |
| 29 | Accident State | Situational, but required where applicable. Always required when E-level ICD9 codes are used. | Use the 2-digit STATE abbreviation to designate the State in which the accident occurred. |
| 30 | Unassigned | Not Used | |
| 31 a & b through 34 a & b | Occurrence Code and Date | Situational, but required where the occurrence code applies to the bill | Use NUBC taxonomy tables for acceptable values |
| 35 a & b through 36 a & b | Occurrence Span Code and Dates | Situational, but required where the occurrence code and span dates apply to the bill | Use NUBC taxonomy tables for acceptable values |
| 37 | Unassigned | Not Used | |
| 38 | Responsible Party Name and Address | Not Used | Providers may complete this field, but it will not be used for claims processing and this information will not be reported back. If used: Name Address City/State/Zip If a 9-digit zip is used, it must be formatted as nnnnn-nnnn with hyphen displayed. |
| 39a,b,c,d through 41a,b,c,d | Value Codes and Amounts | Situational, but required where the occurrence code and span dates apply to the bill | Use NUBC taxonomy tables for acceptable values |
| 42 | Revenue Code | Required on both inpatient and outpatient claims | Use NUBC taxonomy tables for acceptable values |
| 43 | Description | Required on paper claims | Use the Standard Abbreviation as determined by NUBC UB04 specifications |
| 44 | HCPCS Code or Rate | REQUIRED as shown to the right | <u>Inpatient:</u> Rev Codes 0100 through 0219 and the 100X series must show the unit room rate. <u>Outpatient:</u> Revenue Codes 0450 through 0459 must be HCPCS coded with the applicable level of care describing the visit. 99281 – Level 1 99282 – Level 2 |

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| | | | 99283 – Level 3 99284 – Level 4 99285 – Level 5 See Appendix A below for a list of all UB Rev Codes that must be HCPCS-coded on the Outpatient UB04 form. |
| 45 | Service Date | Inpatient: Do not Use Outpatient: Required | MMDDYY |
| 46 | Service Units | REQUIRED as shown to the right | <u>Inpatient:</u> Rev Codes 0100 through 0219 and the 100X series must show the number of days billed for each accommodation. <u>Outpatient:</u> UB Rev Code 0762 requires number of hours not to exceed 23. Other codes may be populated at provider's discretion. |
| 47 | Total Charges | Required | |
| 48 | Non-Covered Charges | Situational, this information is required if some of the charges shown in field 47 are not covered or if some dates of services reflected in the charges in field 47 have been denied by DCHP utilization management. | Inpatient Claims: The charges represented in field 47 that fall on dates of service that were denied by utilization management, must be reflected in this column. |
| 49 | Unassigned | Not Used | |
| 50 | Payer Name | Required | Use multiple lines (a,b,c) if there is more than one payer. DCHP will always be the payer of last resort. Providers must bill other insurance and reflect the payment and denial on the bill send to DCHP. |
| 51 | Health Plan ID | Not required for STAR or CHIP claims | NOTE: This field may become mandatory once health plans are assigned their own National Plan Identifier. |
| 52 | Release of Information | Required | Y = Yes N = No |
| 53 | Benefits Assigned | Required | Y = Yes |

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| | | | All CHIP and STAR claims must indicate YES. |
| 54 | Prior Payments | Situational | Enter any dollar amount paid by the payer on this claim |
| 55 | Estimated Amount Due | Not Required | |
| 56 | NPI | Required | The 10-digit NPI number of the BILLING PROVIDER identified in field 1 on the UB04 |
| 57 | Other Billing Provider | Not Required | |
| 58 | Insured Name | Required | Name of the insured person for the insurance shown in field 50. For STAR and CHIP this will always be the PATIENT. |
| 59 | Insured Relationship to Patient | Required | Use NUBC taxonomy tables for acceptable values For STAR and CHIP this will always = 18 |
| 60 | Insured's Unique ID | Required | Insurance ID# assigned by the health plan of payer to the insured person <u>CHIP</u> : 9-character numbers starting with a alpha character and followed by 8 numeric characters <u>STAR</u> : 9-numeric characters |
| 61 | Group Name | Required for other insurance Not Required for STAR and CHIP | Enter the name of group, which is will usually be the employer through which the insurance is received. For STAR and CHIP, this field can be left blank or can be populated with "DCHP". |
| 62 | Insurance Group Number | Required for other insurance Not Required for STAR and CHIP | Enter the group ID# assigned by the applicable payer. For STAR and CHIP this field can be left blank. |
| 63 | Treatment Authorization Codes | Situational | If prior authorization code was given for the services represented in the claim, enter than number in this space. |
| 64 | Document Control Number | Situational | If re-submitting a claim that was previously adjudicated, |

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| | | Required only for a claim re-submission | enter the Internal Control Number shown on the DCHP Explanation of Payment (EOP) form. |
| 65 | Employer Name | Required for other insurance Not Required for STAR and CHIP | Enter the name of the employer who provides the insurance to the person shown in field 58 |
| 66 | Diagnosis Code Qualifier | Required | Should always = 9 to indicate ICD9 code. |
| For all codes entered in field 67 through 74 decimals are assumed and should not be stated. | | | |
| 67 | Principal or Present on Admission Code | Required | Inpatient: Enter the principal diagnosis as defined by CMS Outpatient: Enter the diagnosis code that describes the reason for the visit |
| 67 A-Q | Other Diagnosis Codes | Situational | Enter all other final diagnosis codes applicable to the visit or addressed in the visit or that explain why the services being billed were performed. |
| 69 | Admit Diagnosis | Inpatient: Required Outpatient: Not Required | Enter the applicable ICD9 codes representing the reason for admission |
| 70 | Patient's Reason for Visit | Inpatient: Not Used Outpatient: Required for Emergency Room, not required otherwise | Enter the applicable ICD9 codes. |
| 71 | PPS Code | REQUIRED for DRG-based hospitals, otherwise this field is not required. | Enter the applicable DRG code determined by the provider that applies to this claim. |
| 72 | External Cause of Injury Code | Situational | Enter the applicable E-level ICD9 code if the treatment was related to an accident |
| 73 | Unassigned | Not Used | |
| 74 | Principal Procedure | Situational | Input the <u>ICD9 surgical procedure code</u> and the <u>date of the surgery</u> applicable to the treatment represented on the claim |
| 74 a-e | Other Procedure | Situational | Input the <u>ICD9 surgical procedure code</u> and the <u>date of the surgery</u> applicable to the treatment represented on the claim |
| 75 | Unassigned | Not Used | |

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| 76 | <p>Attending Provider Name and Identifiers</p> <p>NOTE: There are 4 distinct fields within this box. Each field must be completed as shown in the far right column.</p> | Required | <p>NPI Attending provider's NPI number</p> <p>QUAL Enter the qualifier of 1D followed by Attending Provider's TPI #</p> <p>LAST Last name of Attending Provider</p> <p>FIRST First name of Attending Provider</p> |
| 77 | <p>Operating Provider Name and Identifiers</p> <p>NOTE: There are 4 distinct fields within this box. Each field must be completed, if applicable, as shown in the far right column.</p> | Situational | <p>NPI Operating provider's NPI number</p> <p>QUAL Enter the qualifier of 1D followed by Operating Provider's TPI #</p> <p>LAST Last name of Operating Provider</p> <p>FIRST First name of Operating Provider</p> |
| 78 | <p>Other Provider Name and Identifiers</p> <p>NOTE: There are 4 distinct fields within this box. Each field must be completed, if applicable, as shown in the far right column.</p> | Situational – if applicable use this field for REFERRING PROVIDER | <p>NPI Referring provider's NPI number</p> <p>QUAL Enter the qualifier of 1D followed by Referring Provider's TPI #</p> <p>LAST Last name of Referring Provider</p> <p>FIRST First name of Referring Provider</p> |
| 79 | Other Provider Name and Identifiers | Situational | <p>NPI Other provider's NPI number</p> |

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| | NOTE: There are 4 distinct fields within this box. Each field must be completed. If applicable, as shown in the far right column. | | <p>QUAL Enter the qualifier of 1D followed by Other Provider's TPI #</p> <p>LAST Last name of Other Provider</p> <p>FIRST First name of Other Provider</p> |
| 80 | Remarks Field | Situational | Used when in the judgment of the provider, the information is needed to substantiate the medical treatment and it is not supported elsewhere within the claim data set. |
| 81 | Code-Code Field | Situational | Used in accordance with the NUBC taxonomy set forth in the NUBC UB04 specifications manual and published by the American Hospital Association. |

Change Log:

| Date | Version | Changes |
|-------------|----------------|---|
| 5-17-07jc | 1.0 | Initial DRAFT version, posted on website but also used internally to vet requirements. |
| 5-27-07jc | 1.1 | Updated as discussed internally. Most critical changes were to the following fields 44 and 46. In addition, Appendix A was added at the end of this document. |
| | | |
| | | |

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APPENDIX A: UB Rev Code That Required HCPCS Coding for all Outpatient Bill Types
(Revenue Codes not applicable to an outpatient claim or that do not require HCPCS coding on an outpatient claims are omitted from the following list)

Disclaimer: Inclusion in the following does not imply that the Revenue Code is a covered service. Please refer to applicable Medicaid regulations and to the UB04 Manual published by the American Hospital Association for details.

| CODES | CODES | CODES | CODES | CODES | CODES |
|-------|-------|-------|-------|-------|-------|
| 029X | 035X | 045X | 056X | 077X | 098X |
| 030X | 040X | 046X | 057X | 090X | 210X |
| 031X | 041X | 047X | 061X | 091X | |
| 032X | 042X | 048X | 073X | 092X | |
| 033X | 043X | 054X | 074X | 096X | |
| 034X | 044X | 055X | 075X | 097X | |

All providers that use the UB04 form are strongly encouraged to subscribe the UB04 Manual published by the American Hospital Association. To the fullest extent possible, Driscoll Children’s Health Plan uses these specifications in processing claims.

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