State of Maine

Department of Health & Human Services (DHHS)

MaineCare

Medicaid Management Information Systems
Maine Integrated Health Management Solution
UB 04 Billing Instructions Guide

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Table of Contents

1. Introduction ... 1
2. UB-04 Claim Form ... 8
3. Form Instructions ... 9
FL 1: BILLING PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER ... 9
FL 2: SERVICE LOCATION ID ... 9
FL 3a: PAT. CNTL #. ... 9
FL 3b: MED. REC. # ... 10
FL 4: TYPE OF BILL ... 10
FL 5: FED. TAX NO. ... 11
FL 6: STATEMENT COVERS PERIOD ... 11
FL 7: RESERVED FOR ASSIGNMENT BY THE NUBC ... 11
FL 8: PATIENT NAME ... 11
FL 8a: PATIENT ID NUMBER ... 11
FL 8b: PATIENT NAME ... 12
FL 9 a — e: PATIENT ADDRESS ... 12
FL 10: BIRTHDATE ... 12
FL 11: SEX ... 12
FL 12 – 15: ADMISSION ... 12
FL 12: ADMISSION DATE ... 13
FL 13: ADMISSION HR ... 13
FL 14: PRIORITY of ADMISSION or VISIT ... 13
FL 15: ADMISSION SRC ... 13
FL 16: DHR ... 14
FL 17: STAT ... 14
FL 18 – 28: CONDITION CODES ... 14
FL 29: ACDT STATE ... 15
FL 30: RESERVED FOR ASSIGNMENT BY THE NUBC ... 15
FL 31 – 34: OCCURRENCE CODES AND DATES ... 15
FL 35 & 36: OCCURRENCE SPAN CODES WITH FROM/THROUGH DATES ... 15
FL 37: RESERVED FOR ASSIGNMENT BY THE NUBC ... 16
FL 38: RESPONSIBLE PARTY NAME AND ADDRESS (CLAIM ADDRESSEE) ... 16
FL 39 – 41: VALUE CODES: CODES, AMOUNTS ... 16
FL 42 — 49: SERVICES ... 16

FL 42: REV CD. 17
Resource Utilization Groups (RUG III) Table 18
FL 43: DESCRIPTION 20
FL 44: HCPCS / RATES / HIPPS CODE 20
FL 45: SERV. DATE 21
FL 46: SERV. UNITS 21
FL 47: TOTAL CHARGES 21
FL 48: NON-COVERED CHARGES 22
FL 49: RESERVED FOR ASSIGNMENT BY THE NUBC 22
LINE 23 FOR FL 42 THROUGH FL 49 GROUPED COLUMNS: MULTI-PAGE COUNT, CREATION DATE AND TOTALS 22
FL 50 — 55 AND 58 — 65 23
FL 50: PAYER NAME 23
FL 51: HEALTH PLAN ID 24
FL 52: REL INFO 24
FL 53: ASG BEN 24
FL 54: PRIOR PAYMENTS 24
FL 55: EST. AMOUNT DUE 24
FL 56: NPI 24
FL 57: OTHER PROVIDER ID 25
FL 58: INSURED’S NAME 25
FL 59: P. REL 25
FL 60: INSURED UNIQUE ID 25
FL 61: GROUP NAME 26
FL 62: INSURANCE GROUP NO. 26
FL 63: TREATMENT AUTHORIZATION CODES 26
FL 64: DOCUMENT CONTROL NUMBER 27
FL 65: EMPLOYER NAME 27
FL 66: DX 28
FL 67: PRINCIPAL DIAGNOSIS CODE & PRESENT ON ADMISSION INDICATOR 28
FL 67 A-Q: OTHER DIAGNOSIS CODES & PRESENT ON ADMISSION INDICATOR 28
FL 68: RESERVED FOR ASSIGNMENT BY THE NUBC 29
FL 69: ADMIT DX 29
FL 70: PATIENT REASON DX 29
FL 71: PPS CODE 29

FL 72: ECI ... 29
FL 73: RESERVED FOR ASSIGNMENT BY THE NUBC ... 29
FL 74: PRINCIPAL PROCEDURE, CODE and DATE ... 29
FL 74 a-e: OTHER PROCEDURE, CODE and DATE ... 30
FL 75: RESERVED FOR ASSIGNMENT BY THE NUBC ... 30
FL 76: ATTENDING ... 30
FL 77: OPERATING ... 30
FL 78: OTHER ... 31
FL 79: OTHER ... 31
FL 80: REMARKS ... 31
FL 81CC a-d: ... 31

List of Figures and Tables

Table 1: MIHMS Provider Types ... 2
Figure 3-1: FL 1 Billing Provider Name, Address & Telephone ... 9
Figure 3-2: FL 2 Service Location ID ... 9
Figure 3-3: FL 3a Patient Control Number ... 9
Figure 3-4: FL 4 Type of Bill ... 10
Table 2: Type of Bill by Provider Type ... 10
Figure 3-5: FL 5 Federal Tax Number ... 11
Figure 3-6: FL 6 Statement Covers Period ... 11
Figure 3-7: Patient Name ... 11
Figure 3-8: FL9a-e Patient Address ... 12
Figure 3-9: FL10 Birthdate ... 12
Figure 3-10: FL11 Sex ... 12
Figure 3-11: FL12 - 15 Admission ... 13
Figure 3-12: FL16 Discharge Hour ... 14
Figure 3-13: FL17 Status ... 14
Figure 3-14: FL18-28 Condition Codes ... 14
Figure 3-15: FL29 ACDT State ... 15
Figure 3-16: FL31-24 Occurrence Codes and Dates ... 15
Figure 3-17: FL35 & 36 Occurrence Span Codes with Dates ... 15
Figure 3-18: FL39-41 Value Codes ... 16
Figure 3-19: FL42-49 Services ... 16

Table 3: Resource Rate 17
Table 4: RUG Table 18
Figure 3-20: NDC Example 20
Figure 3-21: Line 23, FL42-49 22
Figure 3-22: FL50 - 55 and FL58 - 65 23
Figure 3-23: FL50 Payer Name 23
Figure 3-24: FL51 Health Plan ID 24
Figure 3-25: FL54 Prior Payments 24
Figure 3-26: FL56 NPI 24
Figure 3-27: FL58 Insured's Name 25
Figure 3-28: FL59 Patient Relationship 25
Figure 3-29: FL60 Insured Unique ID 25
Figure 3-30: FL61 Group Name 26
Figure 3-31: FL62 Insurance Group Number 26
Figure 3-32: FL63 Treatment Authorization Codes 26
Figure 3-33: FL64 Document Control Number 27
Figure 3-34: FL65 Employer Name 27
Figure 3-35: FL67 Principal Diagnosis 28
Figure 3-36: FL74 Principal Procedure, Code and Date 29
Figure 3-37: FL76 Attending 30
Figure 3-38: FL80 Remarks 31

1. Introduction

This document provides billing instructions for institutional services provided to MaineCare members when submitting paper claims for processing in the Maine Integrated Health Management Solution (MIHMS). As alternatives to paper, providers are encouraged to submit claims using the HIPAA compliant EDI 837I format or by Direct Data Entry (DDE), which is an online process where data is directly entered into MIHMS for processing and payment. These paperless alternatives provide countless efficiencies for claims processing without the traditional problems associated with the submission of paper claims such as getting lost in the mail, data entry errors, delayed adjudication, etc. Providers electing to use DDE or EDI must register as a Trading Partner after successful enrollment in MaineCare.

Providers are encouraged to use these paper alternatives and may reach out for support by calling customer support at 1-866-690-5585.

- Direct Data Entry is an option for MaineCare providers that will work well for providers who would like to submit Claims, Authorizations, and Referrals directly into MIHMS. These functions can be done one at a time, or set up using rosters to make the entry easier.
- Providers may also submit batch transaction files in the HIPAA compliant X12 EDI format.
- Additional information can be found for these billing options at the MIHMS website at: https://mainecare.maine.gov/.

The instructions contained in this document are to be followed for completing the claim form for the submitted dates of service to include September 1, 2010 forward. Service dates prior to September 1, 2010 will not be processed by MIHMS, but will follow different billing instructions as specified in the MECMS billing requirements. Providers who need assistance with billing MECMS claims contact your State Provider Relations Specialist at 1-800-321-5557.

The UB-04 claim is a billing form maintained by the National Uniform Billing Committee (NUBC). Each payer, including MaineCare, has different requirements for completing specific parts of the claim form. The MaineCare instructions are adapted from the UB-04 manual developed by the NUBC and approved by the State National Uniform Billing Committee in Maine. For contact information about the NUBC and its manuals, go to http://www.nubc.org and for information about the State Uniform Billing Committee in Maine go to http://www.aahamme.org/subc Use the UB-04 manual to follow these instructions. In many Form Locators (FL), go to the UB-04 manual for specific codes or other information.

Providers are responsible for obtaining their own UB-04 forms; the Maine Department of Health and Human Services (DHHS) does not provide them. These forms can be bought at office supply centers and from other sources including:

U.S. Government Printing Office
Mail Stop: IDCC
732 N. Capitol St. NW
Washington, DC 20401
http://www.gpo.gov/

General Guidance on Submitting Claims

Claim types by MIHMS Provider Types are listed in the following table.

Table 1: MIHMS Provider Types

MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Adult Day Health	19, 26	**No**	√	
Advanced Practice Registered Nurse Group	14, 96	**Yes**	√	
Advanced Practice Registered Nurse	13, 14, 96	**No**	√	
Alternative Residential Facility	2	**No**		√
Ambulance Note: Hospital owned Ambulance services should be billed on the UB form.	5, 113	**No**	√	
Assisted Living Service Provider	96	**No**	√	
Audiology (Group)	35, 109	**Yes**	√	
Audiologist	35, 109	**No**	√	
Behavioral Health Clinicians Group	65	**Yes**	√	
Behavioral Health Clinician Note: BHC with SP 167 BCBA will attest to 21/28/107	13, 65, 21, 28, 107	**No**	√	
Boarding Home	97	**No**		√
Case Management	12,13, 19, & 96	**No**	√	
Children's Community Rehabilitation	28	**No**	√	
Chiropractic Group	15	**Yes**	√	
Chiropractor	15	**No**	√	
Community Health Center / FQHC, RHC, IHS	31, 103, 9	**No**		√
Dialysis Center - Free Standing	7	**No**		√
DME Supplier	35, 60	**No**	√	
Early Childhood	28	**No**	√	
Family Planning Agency	30	**Yes**	√	
Fiscal Employer Agent	12, 19, & 96	**No**	√	
Group Home (Developmentally Disabled)	50	**No**		√
Government Agency	13			

MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Home Health Agency	19, 20, 40 & 96	**No**		√
Hospice	43	**No**		√
Hospital (see notes below) / Hospital, Critical Access	45	**No**		√
Note: Hospitals are required to split bill their professional services to a CMS1500 in a manner that mirrors their Medicare billing	various	**Yes**	√	
Indian Health Services Provider Note: IHS providers enrolling as a Community Provider must follow guidelines for that Provider Type.	9	**Yes**	√	
Intermediate Education Unit	28,	**No**	√	
	68, 85 &109	**Yes**	√	
Interpreter Services for Dental Providers	25	**No**	√	
Laboratory/Radiology	55, 62 & 101	**No**	√	
Medical Food Supplier	60	**No**	√	
Mental Health Clinic / Behavioral Health Services, Community Support Services	17, 23, 65	**Yes**	√	
Developmental and Behavioral Health Clinic		**No**	√	
Mental Health Clinic - ACT		**No**	√	
Mental Health Clinic – Intensive Case Management		**No**	√	
Nurse	13, 19, 96	**No**	√	
Nursing Home	19, 26, 50, 67 & 97	**No**		√
Occupational/Physical Therapy Group	19, 68 & 85	**Yes**	√	
Occupational Therapist	19 & 68	**No**	√	
Physical Therapist	19 & 85	**No**	√	
Psychiatric Residential Treatment Facility	107	**No**		√
Optician	35, 75	**No**	√	
Optometrist	75	**No**	√	
Pharmacy	35, 80	**No**	**None**	
Physicians Group	90	**Yes**	√	

MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Physician	90	**No**	√	
PNMI - Private Non-Medical Institution	97	**No**		√
Podiatry Group	95	**Yes**	√	
Podiatrist	95	**No**	√	
PCA Agency	19, 96	**No**	√	
Psychiatric Hospital	46	**No**		√
Note: Psychiatric Hospitals are required to bill their professional services in a manner that mirrors their Medicare billing	various	**Yes**	√	
Public School	28, 65 & 96	**No**	√	
	68, 85 &109	**Yes**	√	
Rehabilitation Center	102	**No**	√	
School Health Center	3	**Yes**	√	
Special Purpose Private School	28, 65 & 68	**No**	√	
	85, 96 & 109	**Yes**	√	
Speech Language Pathology Group	19, 109	**Yes**	√	
Speech Language Pathologist	19, 109	**No**	√	
Speech/Hearing Therapist Group	35, 109	**Yes**	√	
State Agency	13, 17, 21, 65	**No**	√	
State Agency / Dentist Public Health	25	**Yes**	√	
State Psychiatric Hospital	46	**No**		√
Substance Abuse Provider	13, 65	**Yes**	√	
Transportation	113	**No**	√	
Vision Center	75	**No**	√	
Vision Services Provider Group	35, 75	**Yes**	√	
Waiver Services Provider	19, 20, 21, 29, 32	**No**	√	
Dental Group	25	**Yes**	**ADA 2006**	

MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Dental Hygienist Group		Yes	ADA 2006	
Denturist Group		Yes	ADA 2006	
Dental Hygienist, Dentist, Denturist,		No	ADA 2006	
Note: Oral Surgeons who provide services outside of Section 25 may bill MaineCare for those services using the CMS1500			√	

1. Billing instructions are intended to assist providers with the preparation of claims, and are intended to supplement the guidance provided in the applicable MaineCare Policy. Policies may be accessed at the following website: http://www.maine.gov/sos/cec/rules/10/ch101.htm
2. Free information is available from CMS for those without a UB manual. See generally http://www.cms.hhs.gov/CMSForms and search for CMS 1450, or go to http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html?redirect=/CMSForms and scroll down to the PDF entitled "UB-04 Medicare Claims Processing."
3. Paper claims will be returned to the provider for any of the following reasons:
   a. Not on an original Claim Form.
   b. The form/attachment is incorrect, not legible, print is too light, and/or the alignment is not correct (1 character out of alignment or more).
   c. Claim is damaged.
   d. The form includes the use of any correction tape or liquid correction fluid or crossed out data.
   e. Claim is completed with red ink.
   f. Attachment is completed with red ink.
   g. An attachment
   h. Is not 8 ½ x 11.
   i. Has double sided content.
   j. Bill Type is missing, or is not 4 digits in length, or, if 4 digits, does not begin with 0.
   k. Federal Tax ID is less than 9 digits.
   l. Patient's First and/or Last name are missing.
   m. Patient's Date of Birth is missing or not in MMDDCCYY or MMDDYY format.
   n. Claim does not have at least one line of detail in lines 1-22.
   o. Creation Date is missing or is not in MMDDCCYY format.
   p. NPI is less than 10 digits or API is less than 10 characters (A followed by 9 digits).
   q. If Insured's ID # is not in one of these four valid formats:
      i. Eight digits followed by A,
      ii. Eight digits followed by T,
      iii. Six digits preceded by T, or
      iv. Six digits followed by T

NOTE: *Additionally, paper claims are translated to an EDI X12 transaction and will be returned for any HIPAA validation errors. Providers will receive a letter indicating the claim is being returned for HIPAA.*

4. Codes

a. In addition to the National UB-04 manual, in order to complete the UB-04 form, utilize the current CPT© (Current Procedural Terminology) of the American Medical Association, the current ICD (International Classification of Diseases) Diagnostic Codes based on date of service, or HCPCS (Healthcare Common Procedure Coding System) Codes maintained by the Centers for Medicare and Medicaid Services; or,
b. Use the Procedure Codes in Chapter III of the *MaineCare Benefits Manual* policy section under which the billing is being performed. Access these codes at the following website: http://www.maine.gov/sos/cec/rules/10/ch101.htm
c. If using ICD codes: for dates of service of 10/01/2015 and forward, use the appropriate ICD-10 code. For dates of service prior to 10/01/2015, use the appropriate ICD-9 code.

***NOTE**: Inpatient claims with dates of service starting prior to 10/01/2015 and ending on or after 10/01/2015, should be billed with the appropriate ICD-10-CM code. Outpatient claims should not be billed with dates of service that span the 10/01/2015 cutover date.*

d. T1013 Sign language or oral interpreter services per fifteen minutes.
e. T1013-GT Interpreter Services provided via documented use of Pacific Interpreters, Language Line, or equivalent telephone interpreting service, must be by report with copies of the invoice attached.

5. Dates
   a. The required format for a birth date is eight digits (MMDDCCYY). (Example: January 19, 1947 = 01191947).
   b. The date format for all other dates is six digits (MMDDYY).
6. Monetary amounts
   a. The format is dollars and cents, with no decimal point, dollar signs (or other currency indicators), and no comma separators. The decimal portion must be positioned to the right of the dashed line and the whole dollar portion to the left. All amounts are in US currency.
7. Mailing the Claim
   a. Mail the completed UB form including replacement or reversal claims to:
      MaineCare Claims Processing
      M-100
      Augusta, ME 04332-0011
8. Attachments and Attachment Uploads
   a. Attachments may be provided in any of the following ways:
      i. Attach paper attachment to a paper claim.
      ii. Attachments may be uploaded through the Portal when submitting claims via Direct Data Entry.
      iii. Attachments may be uploaded through the Portal for claims previously submitted by searching for the matching claim in Claims Status and uploading a scanned attachment directly to the claim.
         1. Acceptable file formats for upload are: PDF, GIF, JPEG/JPG, TIFF, MS Word, and MS Excel.
         2. **Attachments must be submitted on the same day. If appropriate attachment is not present when the claim is being reviewed, it will deny.**
   b. Claims with prior payments must include an Explanation of Benefits.
   c. Submitting claims to Maine Care when primary insurance has denied the service, an explanation of benefits must be included.
   d. When submitting claims after Medicare C Plans, write “Medicare” on the Explanation of Benefits.

e. Spend down letters should be attached for each claim where the member has a coverage code of "Spend Down" for that particular date of service.
f. Abortion form should be submitted along with the claim. This service is not prior authorized. Submit the required documentation along with the claim form after the service is performed. The form is signed by the physician and attests to certain conditions.

9. Form Locator Usage
    a. These instructions include description of whether each Form Locator is Required, Situational, Optional, or Not Used, according to these definitions:
        i. Required - This item must be completed with the proper information as specified.
        ii. Situational - This item must be completed with the proper information, if the stated triggering event applies.
        iii. Optional - This item can be completed at your discretion (for example, to avoid having to file claims differently for MaineCare), but if used, must contain the information specified by NUBC Data Specifications Manual, or as superseded by these instructions, if they differ.
        iv. Not Used - This item need not be completed as MaineCare/MIHMS never looks at this field.

2. UB-04 Claim Form

1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME a b
9 PATIENT ADDRESS a b c d e
10 BIRTHDATE
11 SEX
ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a b c d

42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23

PAGE ____ OF ____
CREATION DATE
TOTALS

50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
A B C

58 INSURED'S NAME
59 P. REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
A B C

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

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

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

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST

80 REMARKS
81CC a b c d

78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450
APPROVED OMB NO. 0938-0997
NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

3. Form Instructions

FL 1: BILLING PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER

1

Figure 3-1: FL 1 Billing Provider Name, Address & Telephone

- Not Labeled on UB
- Required
  - Line 1: Name,
  - Line 2: Address – Must be a physical address; not a PO Box
  - Line 3: City, State, and 9-digit ZIP code
  - Line 4: Telephone number

FL 2: SERVICE LOCATION ID

2

Figure 3-2: FL 2 Service Location ID

- Not Labeled on UB.
- Situational (Required if provider has more than one service location, unless the service location and billing provider address are the same.)
  - The service location ID is not needed if:
    - The provider has enrolled with only one service location within MaineCare.
    - The service location and the billing provider address are the same.
- Service Location ID: 10 Digit NPI or API plus the 3-digit servicing location identifier of -001, -002, etc. (ex. 1234567890-003).
  - Line 1 - Facility Name
  - Line 2 – Address – Must be a physical address: not a PO Box
  - Line 3 - City, State, and 9-digit Zip code
  - Line 4 - Service Location ID

FL 3a: PAT. CNTL #.

3a PAT. CNTL #	
b. MED. REC. #	

Figure 3-3: FL 3a Patient Control Number

- Required

- Please enter internal numbering or accounting system identifier in this location.
- The maximum length 38 but MaineCare will only return 20 characters.

FL 3b: MED. REC.

- Not Used

FL 4: TYPE OF BILL

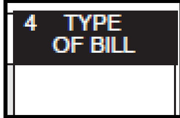

Figure 3-4: FL 4 Type of Bill

- Required
    - Please use the National UB-04 manual for specific codes.
    - Enter the four-digit code from the National UB-04 manual for the provider type that indicates the type of bill using the following guidance by Provider Type.
    - Hospitals must use appropriate TOB when billing for serious reportable events.
    - Hospitals that receive DRG reimbursement are able to bill separately using Type of Bill 0121 to receive additional payment for Long Active Reversible Contraceptives (LARC). The LARC needs to be implanted directly after delivery while the mother is receiving inpatient services.

Table 2: Type of Bill by Provider Type

Hospital	011x, 012x, 013x, 014x 018x
Critical Access Hospital	011x, 018x or 085x
Nursing Facility	021x , 022x or 023x
Nursing Facility (ICF-IID)	021x or 022x
Home Health	032x, 033x or 034x
ICF-IID	021x/022x
PNMIs/	
Appendices C and F	065x or 066x
Appendices B, D, and E	086x
Rural Health Center (RHC)	071x
Freestanding Renal Dialysis Center	072x
Federally Qualified Health Center (FQHC)	077x
Hospice	081x or 082x
Alternative Residential Facility (Formerly Adult Family Care Home)	089x
Psychiatric Residential Treatment Facility (PRTF)	086x

FL 5: FED. TAX NO.

5 FED. TAX NO.

Figure 3-5: FL 5 Federal Tax Number

- Required
  - Enter the provider's Federal Tax Number (Employer Identification Number/EIN). This number is required for Federal income tax purposes.
  - As with other FLs on the UB, the Federal Tax number goes in the empty box just below the box labeled 5 FED TAX NO. MaineCare will ignore a sub-ID in the space next to 5 FED TAX NO, although this practice is described in the UB manual.

FL 6: STATEMENT COVERS PERIOD

6 STATEMENT COVERS PERIOD FROM	THROUGH

Figure 3-6: FL 6 Statement Covers Period

- Required
  - If all services were provided on a single day, enter that date in both the FROM and THROUGH fields.
    - The date format is six digits: MMDDYY.
    - Do not use commas, dashes, or slashes in the date.
  - Inpatient and Outpatient Hospital claims may overlap months. All other providers must bill no more than one calendar month on a claim form.
  - FROM
    - Enter the date that services on this claim began.
  - THROUGH
    - Enter the date that services on this claim ended, including the discharge date, if applicable.

FL 7: RESERVED FOR ASSIGNMENT BY THE NUBC

- Not Labeled on UB
- Not Used

FL 8: PATIENT NAME

8 PATIENT NAME	a	
b		

Figure 3-7: Patient Name

FL 8a: PATIENT ID NUMBER

- Optional
- See FL 60 for where to enter the MaineCare member ID.

FL 8b: PATIENT NAME

- Required
  - Enter the member's name in this order: last name, first name, and middle initial. The name must be exactly the same as the name printed on the member's MaineCare ID card.

FL 9 a — e: PATIENT ADDRESS

- a through d are required; e is not required.

Figure 3-8: FL9a-e Patient Address

- FL 9a: Enter the member's street address or P.O. Box.
- FL 9b: City
- FL 9c: State
- FL 9d: ZIP Code
- FL 9e: Country Code – Situational (required if country is other than USA).

FL 10: BIRTHDATE

Figure 3-9: FL10 Birthdate

- Required
  - Enter the patient's date of birth. A birth date must be in eight-digit format (MMDDCCYY).

FL 11: SEX

Figure 3-10: FL11 Sex

- Required
  - Enter the patient's sex as M, F, or U.
    - M=Male
    - F=Female
    - U=Unknown

FL 12 – 15: ADMISSION

Figure 3-11: FL12 - 15 Admission

FL 12: ADMISSION DATE

- Situational (Required if noted below).
  - Enter the date the member was admitted to the facility if the provider type and Type of Bill (TOB) is:
    - Alternative Residential Facility – TOB 086x
    - Hospice – TOB 081x & 082x
    - Hospital – TOB 011x, 012x & 018x
    - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) – TOB 021x & 028x
    - Nursing Facility – TOB 021x & 028x
    - Private Duty Nursing – TOB032x, 033x & 034x
    - Private Non-Medical Institution (PNMI, ICF-IID) – TOB 065x, 066x & 089x
    - Psychiatric Facility – TOB 011x
    - Religious Non-medical Health Care Institutions – TOB 041x
    - Psychiatric Residential Treatment Facility (PRTF) - TOB 086x
  - Enter the date this episode of care began if the provider type is:
    - Home Health – TOB 032x, 033x & 034x
  - The format for the date is six digits (MMDDYY).
    - Do not use commas, dashes, or slashes in the date.
  - If the admission date is later than the FROM date in FL 6, the claim will deny for invalid dates billed.

FL 13: ADMISSION HR

- Situational (Required for inpatient Hospital bills only except Type of Bill 012x).
  - Enter the two digit code indicating the hour that the patient was admitted from inpatient care.
  - Please use the National UB-04 manual for specific codes.

FL 14: PRIORITY of ADMISSION or VISIT

- Required
  - Enter the admission type.
    - See the National UB-04 manual for specific codes.

FL 15: ADMISSION SRC

- Situational (Required on all bill types except 014x)).
  - Enter the source of admission. Please see the National UB-04 manual for specific codes.
  - Do not enter an admission source for an outpatient.

- Except when billing secondary to Medicare for outpatient diagnostic testing services.

FL 16: DHR

16 DHR

Figure 3-12: FL16 Discharge Hour

- Situational (Required on all final inpatient claims (IP) except 021x. This includes claims with a frequency code of 1 (admit through discharge), 4 (interim – last claim), and 7 (replacement of prior claim) when the replacement is for a final claim.
  - Enter the code indicating the hour that the patient was discharged from inpatient care.
    - Please use the National UB-04 manual for specific codes.

FL 17: STAT

17 STAT

Figure 3-13: FL17 Status

- Required
  - Enter a code indicating patient status as of the ending service date of the period covered on the bill, as reported in FL 6, Statement Covers Period.
    - Please use the National UB-04 manual for specific codes.
  - See UB-04 manual for a list of useful FAQs.

FL 18 – 28: CONDITION CODES

CONDITION CODES										
18	19	20	21	22	23	24	25	26	27	28

Figure 3-14: FL18-28 Condition Codes

- Situational
  - Enter codes used to identify conditions relating to the bill that may affect payer processing.
  - Use condition code 45 (Ambiguous Gender Category) to identify services that are gender specific (i.e., services that are considered female or male only.) This condition code should only be used on claims relating to transgender, ambiguous genitalia, or hermaphrodite issues.
  - Use condition code AH for State Funded Abortion Services on inpatient claims.
  - Three codes with special significance are:
    - Use Code AJ for services, including emergency services, to bypass the MaineCare co-pay requirement (as allowed by the *MaineCare Benefits Manual*).
    - Always use Code A1 to identify an EPSDT – related claim.
    - Use B3 (Pregnancy Indicator) to bypass the MaineCare co-pay requirement (as allowed by the *MaineCare Benefits Manual*).
  - Please see the National UB-04 manual for the full list of specific codes.

FL 29: ACDT STATE

29 ACDT STATE

Figure 3-15: FL29 ACDT State

- Situational
  - If Occurrence Codes 01-05 are used in Field Locators 31-34 enter the two-character Accident State.

FL 30: RESERVED FOR ASSIGNMENT BY THE NUBC

- Not Labeled on UB
- Not Used

FL 31 – 34: OCCURRENCE CODES AND DATES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE

Figure 3-16: FL31-24 Occurrence Codes and Dates

- Situational
  - If applicable, enter the code and associated date defining a specific significant event relating to the bill that may affect payer processing.
  - For example, Jan 5-10 Medicare Benefits exhausted (A3).
  - For example, the date active care ended (22).
    - Please see the National UB-04 manual for specific codes.

FL 35 & 36: OCCURRENCE SPAN CODES WITH FROM/THROUGH DATES

35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH

Figure 3-17: FL35 & 36 Occurrence Span Codes with Dates

- Situational
  - If applicable, enter a code and related dates that identify an event that spans time and relates to the payment of the claim.
    - Please see the National UB-04 manual for specific codes.
  - To bill for services not covered by Medicare, use the occurrence span code 74 with the occurrence span dates which encompass the to and from dates of service being billed on the claim.
    - The span code 74 indicates Medicare will not pay for the level of care needed for the member.

FL 37: RESERVED FOR ASSIGNMENT BY THE NUBC

- Not Labeled on UB
- Not Used

FL 38: RESPONSIBLE PARTY NAME AND ADDRESS (CLAIM ADDRESSEE)

- Not Labeled on UB
- Not Used

FL 39 – 41: VALUE CODES: CODES, AMOUNTS

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

Figure 3-18: FL39-41 Value Codes

- If a MaineCare patient has Medicare as the primary payer, or is responsible for a spend down amount, enter that information in FL 39, 40, or 41. In the Code fields (39, 40, and 41), use the following:
  - A1 = Deductible Payer A (B1, C1 ...)
  - A2 = Coinsurance and/or Copayment Payer A (B2, C2 ...)
  - 66 = Medicaid Spend down amount
  - A7 = Co-Payment Payer A (B1, C1, …)
  - 80 = Covered Days
  - 81 = Non-Covered Days
  - 82 = Coinsurance Days
  - 83 = Lifetime Reserve Days
- Please see the National UB-04 manual for complete instructions and specific codes.
- In the Amount fields, after the appropriate code, enter the amount. Enter integer values to the left of the dashed line so that no decimal point will be added.
- When using value codes 80 – 83 the number of days are right-justified to the left of the dollars/cents delimiter, use zeros in the cents field.
- Do not enter other third-party co-insurance/ deductible.
- On all claims do not enter a patient assessment/cost of care.

FL 42 — 49: SERVICES

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	NDC N499999999999	HCPCS left justified Rate right justified					

Figure 3-19: FL42-49 Services

FL 42: REV CD.

- Required
  - Enter a four-digit code that identifies a specific accommodation, ancillary service, or billing calculation.
    - See the National UB-04 manual for specific codes.
  - Alternative Residential Facilities
    - Bill revenue code 3104 (Charges in FL47 must reflect the appropriate Resource Rate.)
      - This revenue code does not require a procedure code in FL 44.

Table 3: Resource Rate

Resource Group	MaineCare Weight	Resource Adjusted Price (Based on $43.26 Unadjusted Price Multiplied by MaineCare weight)
1	1.657	$71.68
2	1.210	$52.34
3	1.360	$58.83
4	1.027	$44.43
5	.924	$39.97
6	.804	$34.78
7	.551	$23.84
8	.551	$23.84

- Revenue code: 0169 Room and Board
  - This revenue code does not require a procedure code in FL 44.
  - In FL 47, a facility less than five years old, should bill $1012.
  - In FL 47, a facility greater than five years old, should bill $787.
    - Dollar signs and decimal points must not be used on the claim form.

- Case Mix Nursing Facilities Billing
  - Bill the 0169 revenue code for the non-case mix element (direct care add-on, routine and fixed).
  - Bill 0022 revenue with HCPCS RUG codes listed in Table 2.
    - The billing HCPCS RUG code will use the three characters RUG III Group (e.g., RUC) and the two-digit extension “00”.
  - For leave days, facilities will bill the following two leave revenue codes when a resident is out of the facility and expected to return:
    - Revenue Code 0185 – Used when a Nursing Home member is hospitalized.
    - Revenue Code 0183 – Used for Therapeutic leave, ex. Home visits
  - When billing for leave days using Revenue Code 0185 or 0183, you cannot bill for direct care using Revenue Code 0022.

- Excluded Nursing Facilities – Contracted Facilities
  - Revenue Code – 0128 – Used for Brain Injury
  - Revenue Code – 0124 –Used for Mental Health

- Revenue Code – 0169 – Remote Island
- All Contracted facilities will bill the following leave revenue codes when a resident is out of the facility and expected to return:
  - Revenue Code 0180 – General leave of absence
  - Revenue Code 0182 – Patient Convenience, ex. Home visits
  - Revenue Code 0185 – Used for Remote Island General leave of absence (for hospitalizations).
  - Revenue Code 0183 – Used for Remote Island Patient Convenience, ex. Home visits

- Billing for any leave days cannot be combined with billing direct care using Revenue Code 0022.

Resource Utilization Groups (RUG III) Table

Table 4: RUG Table

Order	Hierarchy	RUG group	HCPCS RUG Code	Description	Weight 512ME
1	Rehab	RUC	RUC00	REHAB ULTRA/ADL 16-18	1.986
2	Rehab	RUB	RUB00	REHAB ULTRA/ADL 9-15	1.426
3	Rehab	RUA	RUA00	REHAB ULTRA/ADL 4-8	1.165
4	Rehab	RVC	RVC00	REHAB VERY HI/ADL 16-18	1.756
5	Rehab	RVB	RVB00	REHAB VERY HI/ADL 9-15	1.562
6	Rehab	RVA	RVA00	REHAB VERY HI/ADL 4-8	1.217
7	Rehab	RHC	RHC00	REHAB HI/ADL 13-18	1.897
8	Rehab	RHB	RHB00	REHAB HI/ADL 8-12	1.559
9	Rehab	RHA	RHA00	REHAB HI/ADL 4-7	1.260
10	Rehab	RMC	RMC00	REHAB MED/ADL 15-18	2.051
11	Rehab	RMB	RMB00	REHAB MED/ADL 8-14	1.635
12	Rehab	RMA	RMA00	REHAB MED/ADL 4-7	1.411
13	Rehab	RLB	RLB00	REHAB LOW/ADL 14-18	1.829
14	Rehab	RLA	RLA00	REHAB LOW/ADL 4-13	1.256
15	Extensive	SE3	SE300	EXTENSIVE 3/ ADL 7-18/TBI-ADL 15-18	2.484
16	Extensive	SE2	SE200	EXTENSIVE 2/ADL 7-18/TBI-ADL 10-14	2.057

Order	Hierarchy	RUG group	HCPCS RUG Code	Description	Weight 512ME
17	Extensive	SE1	SE100	EXTENSIVE 1/ADL 7-18/TBI-ADL 7-9	1.910
18	Special Care	SSC	SSC00	SPECIAL CARE /ADL 17-18	1.841
19	Special Care	SSB	SSB00	SPECIAL CARE/ADL 15-16	1.709
20	Special Care	SSA	SSA00	SPECIAL CARE/ADL 4-14	1.511
21	Clinically Comp	CC2	CC200	CLIN. COMP W/DEP/ADL 17-18	1.826
22	Clinically Comp	CC1	CC100	CLIN. COMP/ADL 17-18	1.663
23	Clinically Comp	CB2	CB200	CLIN. COMP W/DEP/ADL 12-16	1.503
24	Clinically Comp	CB1	CB100	CLIN. COMP/ADL 12-16	1.389
25	Clinically Comp	CA2	CA200	CLIN. COMP W/DEP/ADL 4-11	1.331
26	Clinically Comp	CA1	CA100	CLIN. COMP/ADL 4-11	1.149
27	Cognitively Imp	IB2	IB200	COG. IMPAIR W/RN REHAB/ADL 6-10	1.199
28	Cognitively Imp	IB1	IB100	COG. IMPAIR/ADL 6-10	1.152
29	Cognitively Imp	IA2	IA200	COG. IMPAIR W/RN REHAB/ADL 4-5	0.945
30	Cognitively Imp	IA1	IA100	COG. IMPAIR/ADL 4-5	0.888
31	Behavioral	BB2	BB200	BEHAVE PROB W/RN REHAB/ADL 6-10	1.180
32	Behavioral	BB1	BB100	BEHAVE PROB/ADL 6-10	1.123
33	Behavioral	BA2	BA200	BEHAVE PROB/ W/RN REHAB/ADL 4-5	0.905
34	Behavioral	BA1	BA100	BEHAVE PROB/ ADL 4-5	0.759
35	Physical	PE2	PE200	PHYSICAL W/RN REHAB/ADL 16-18	1.454
36	Physical	PE1	PE100	PHYSICAL /ADL 16-18	1.421

Order	Hierarchy	RUG group	HCPCS RUG Code	Description	Weight 512ME
37	Physical	PD2	PD200	PHYSICAL W/RN REHAB/ADL 11-15	1.323
38	Physical	PD1	PD100	PHYSICAL/ADL 11-15	1.281
39	Physical	PC2	PC200	PHYSICAL W/RN REHAB/ADL 9-10	1.219
40	Physical	PC1	PC100	PHYSICAL/ADL 9-10	1.088
41	Physical	PB2	PB200	PHYSICAL W/RN REHAB/ADL 6-8	0.833
42	Physical	PB1	PB100	PHYSICAL/ADL 6-8	0.854
43	Physical	PA2	PA200	PHYSICAL W/RN REHAB/ADL 4-5	0.776
44	Physical	PA1	PA100	PHYSICAL /ADL 4-5	0.749
45	Not Classified	BC1	AAA00	NOT CLASSIFIED	0.749

FL 43: DESCRIPTION

- Situational
  - When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line.
    - The NDC is to be preceded with the qualifier N4 and followed immediately by the 11-digit NDC code (e.g. N499999999999). The11-digit NDC number is printed on the drug package in a 5-4-2 format. If the segments do not have the appropriate number of digits, you will need to add zeros at the beginning of the segment.
    - Report the NDC quantity in the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter) or ME (milligrams). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

N401234012312

Figure 3-20: NDC Example

FL 44: HCPCS / RATES / HIPPS CODE

- Required
  - For inpatient bills, enter the accommodation rate.
    - When the rate is entered, it must be right-justified in the column.
  - For outpatient bills, enter the appropriate Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT©) codes.
    - When a code is entered, it must be left-justified in this column.

- To be as accurate as possible, various HCPCS and CPT© codes may require the use of modifiers.
  - Use the appropriate modifier along with the procedure code.
  - Hospitals must use appropriate modifiers when billing for serious reportable events. If any services provided during that same day are reimbursable to bill those on a separate line.
  - Institutional-based providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:
    - QM - Ambulance service provided under arrangement by a provider of services; or
    - QN - Ambulance service furnished directly by a provider of services. While combinations of these items may duplicate other HCPCS modifiers, when billed with an ambulance transportation code, the reported modifiers can only indicate origin/destination.
    - FP- Family planning services are those provided to prevent or delay pregnancy or to otherwise control family size. Counseling services, laboratory tests, medical procedures and pharmaceutical supplies and devices are covered if provided for family planning purposes.
    - SE - State Funded Abortion Services requires SE modifier on every line on the claim. Unrelated services should be billed on a separate claim.
    - State Supplied Vaccines require the use of the SL modifier on the vaccine code only. SL modifier should not be appended on the administration code.

FL 45: SERV. DATE

- Situational (Required for certain outpatient claims)
  - For outpatient claims for occupational, physical or speech therapy services, home health, nursing facilities, etc., enter the date that the indicated service was provided.
  - For pharmacy revenue code 0636 enter the date that the drug was administered.

FL 46: SERV. UNITS

- Required
  - For inpatient claims, enter the number of days of inpatient accommodations.
  - For outpatient claims, if the same service was provided more than once on the same day, enter the number of units provided.
    - For example, if two EKGs were provided on the same day, enter two units.
  - For inpatient claims:
    - Include the date of admission, but do not include the date of discharge.
  - Units must equal the number of days in the “statement covers period” except on discharge claims.
    - If the member is discharged the total covered days is one less than the covered period. The number of covered days is reflected in FL 39, 40 or 41 by using value code 80 and the number of days.
  - All services— except inpatient and outpatient hospital—must bill no more than the number of days in one calendar month on a single claim form.

FL 47: TOTAL CHARGES

- Required

- Enter the total charges pertaining to the related revenue code for the current billing period, as entered in the statement's covered period (FL 6).
- The total must be reported by completing line 23 on the final claim page as follows:
  - In column 42, enter revenue code 0001.
  - In column 47, enter the total of charges from all pages.
  - In column 48, enter the total of non-covered charges from all pages, if applicable.

FL 48: NON-COVERED CHARGES

- Situational
  - If applicable, enter the non-covered charges pertaining to the related revenue code. Line 23 must reflect the total of this column.
  - If the claim contains an ICD diagnosis or procedure code for circumcision the charges related to the circumcision must be placed in the non-covered charges column.
  - If the facility does not enter non-covered charges for the circumcision, do not put the ICD diagnosis or procedure code on the claim.
  - If this column is completed and the charges are for non-covered days, the number of days must be reflected in FL 39, 40 or 41 using Value Code 81.
  - If using ICD codes: for dates of service of 10/01/2015 and forward, use the appropriate ICD-10 code. For dates of service prior to 10/01/2015, use the appropriate ICD-9 code.

***NOTE**: Inpatient claims with dates of service starting prior to 10/01/2015 and ending on or after 10/01/2015, should be billed with the appropriate ICD-10-CM code. Outpatient claims should not be billed with dates of service that span the 10/01/2015 cutover date.*

FL 49: RESERVED FOR ASSIGNMENT BY THE NUBC

- Not Labeled on UB
- Not Used

LINE 23 FOR FL 42 THROUGH FL 49 GROUPED COLUMNS: MULTI-PAGE COUNT, CREATION DATE AND TOTALS

23 PAGE ____ OF ____ CREATION DATE TOTALS 23

Figure 3-21: Line 23, FL42-49

- Incrementing Page Count Situational **(Required if multi-page claim).**
- The first third of the 23rd line contains an incrementing page count and total number of pages for the claim on each page only using Revenue Code 0001.
- Creation Date Required.
- The middle third of the 23rd line contains the creation date of the claim on each page.
  - If used, enter in eight-digit date format (MMDDCCYY).
- Totals Required.
- The right-hand third of the 23rd line contains the claim total of both covered and non-covered charges on the final claim page.

FL 50 — 55 AND 58 — 65

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

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

Figure 3-22: FL50 - 55 and FL58 - 65

- For Requirements, see each field.
  - For these Form Locators, each line represents a payer. For any item in any column on Line A, the primary payer, must correspond to the same entity for every occurrence. The same applies to Lines B and C.

FL 50: PAYER NAME

50 PAYER NAME

Figure 3-23: FL50 Payer Name

- Line A, Required; Lines B and C, Situational (Required if there are additional payers).
  - On lines A–C, enter the name that identifies each payer organization from which the provider might expect some payment for the bill.
    - The payer names must be spelled out, for example, Medicare, Anthem Blue Cross, and MaineCare. When the payer is Medicare C list it as “Medicare”.
  - Lines:
    - A – Enter primary payer
    - B – Enter secondary payer
    - C – Enter tertiary payer
  - Important: MaineCare is the payer of last resort. Note: If MaineCare is the only payer in FL 50 then FL 54, 59, 61, and 62 are not required.
    - The payer names must be spelled out, for example, Medicare, Anthem Blue Cross, MaineCare.
  - Lines in FL 50 must correspond to lines in FL 51, 54, 58, 59, 60, 61, and 62.
  - If MaineCare is the only payer in FL 50, it is not required to complete FL 54, 59, 61, and 62.

FL 51: HEALTH PLAN ID

51 HEALTH PLAN ID

Figure 3-24: FL51 Health Plan ID

- Situational (Required for providers with Atypical Provider Identifier or API).
    - Enter a provider's API on whichever line (A, B, or C) is identified as MaineCare in FL 50.

FL 52: REL INFO

- Not Used

FL 53: ASG BEN

- Not Used

FL 54: PRIOR PAYMENTS

54 PRIOR PAYMENTS

Figure 3-25: FL54 Prior Payments

- Situational (Not required if MaineCare is the only payer).
    - If there are one or more other payers listed in FL 50, enter the prior payments, except MaineCare. If the third-party payment exceeds MaineCare reimbursement, no additional payment will be made.
    - Never put a prior MaineCare payment in this form locator. Enter prior payment(s) from all other parties.

FL 55: EST. AMOUNT DUE

- Not Used

FL 56: NPI

56 NPI
57
OTHER
PRV ID

Figure 3-26: FL56 NPI

- Required
  - Enter Pay-To Provider's NPI

FL 57: OTHER PROVIDER ID

- Not Used

FL 58: INSURED'S NAME

58 INSURED'S NAME

Figure 3-27: FL58 Insured's Name

- Required
  - Enter the MaineCare member's name in this order: last name, first name, middle initial.
    - MaineCare considers the member as the "insured."
  - The member's name must be exactly as shown on the MaineCare ID card on the line corresponding to MaineCare.
  - Use the appropriate line (A, B, or C) that corresponds to FL 50.

FL 59: P. REL

59 P. REL

Figure 3-28: FL59 Patient Relationship

- Situational (Not required if MaineCare is the only payer).
  - If the patient is covered by insurance under another policyholder, enter the two-digit code to indicate the patient's relationship to the policyholder.
    - Codes are listed in the National UB-04 Manual.

FL 60: INSURED UNIQUE ID

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

Figure 3-29: FL60 Insured Unique ID

- Required
  - Enter the member's MaineCare ID number as shown on the member's MaineCare ID card, certificate number, or other insurance ID number.
  - Use the appropriate line (A, B, or C) that corresponds to FL 50.
  - **Do not enter the member's Social Security number in place of the MaineCare ID number. This will cause the claim to deny.**

FL 61: GROUP NAME

61 GROUP NAME

Figure 3-30: FL61 Group Name

- Situational: Not required if MaineCare is the only payer.
    - If the member is covered by other insurance, enter the insured's Group Name.
        - Primary payer information is required if MaineCare is the secondary payer.
    - Use the appropriate line (A, B, or C) that corresponds to FL 50.

FL 62: INSURANCE GROUP NO.

62 INSURANCE GROUP NO.

Figure 3-31: FL62 Insurance Group Number

- Situational: Not required if MaineCare is the only payer.
    - If applicable, enter the Group Number for the insurance named in FL 61.
        - Primary payer information is required if MaineCare is the secondary payer.

FL 63: TREATMENT AUTHORIZATION CODES

63 TREATMENT AUTHORIZATION CODES

Figure 3-32: FL63 Treatment Authorization Codes

- Situational: Required for services needing prior authorization when PA numbers are needed at a line level. See special billing instructions for populating PA numbers on claims (Prior Authorization Numbers and Claim Submissions.)
    - Psychiatric Residential Treatment Facility (PRTF) providers billing room & board code 0169 should not enter a PA number on the claim line.
    - If services have been prior authorized, enter the Prior Authorization number (PA) on lines A, B, or C.
    - Use the appropriate line (A, B, or C) that corresponds to MaineCare in FL 50.

FL 64: DOCUMENT CONTROL NUMBER

64 DOCUMENT CONTROL NUMBER

Figure 3-33: FL64 Document Control Number

- Situational (required for replacement or reversal of a claim).
  - If this is an adjustment claim (reversal or replacement), enter the Claim ID of the claim being reversed or replaced. **The Claim ID must be on line (A, B, or C) relevant to MaineCare.**
  - 7 – For Replacement of a previous claim – this function negates the original claim and processes the information in FL 42 – 47 as a new claim.
    - Example: If a claim is submitted for July and later a rate letter is received to increase the rate effective in July:
      - Enter a 7 as the fourth digit in FL 4.
      - The correct information is entered in FL 42-47.
      - The original claim ID is entered in FL 64.

    The system will take back the original payment (shown under adjustments on the RA) and process the new information and a remittance showing a payment for the new claim would be sent.
  - 8 – for Reversal or Cancel
    - Example: It was later determined that the service never occurred.
      - A reversal claim must be submitted by putting an 8 as the fourth digit in FL 4.
      - The original claim ID is entered in FL 6.4

    The system will take back the original payment (shown under adjustments on the RA) and a remittance statement will be sent from MaineCare showing a negative amount on the line for that claim.

FL 65: EMPLOYER NAME

65 EMPLOYER NAME

Figure 3-34: FL65 Employer Name

- Situational
  - The name of the employer that provides health care coverage for the individual identified in FL 58.

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FL 66: DX

- Required
  - The Diagnosis and Procedure Code Qualifier value must be '9' for ICD-9 or '0' for ICD-10. For dates of service of 10/01/2015 and forward, use the '0' qualifier for ICD-10. For dates of service prior to 10/01/2015, use the '9' qualifier for ICD-9.

***NOTE**: Inpatient claims with dates of service starting prior to 10/01/2015 and ending on or after 10/01/2015, should be billed with the appropriate ICD-10-CM code. Outpatient claims should not be billed with dates of service that span the 10/01/2015 cutover date.*

FL 67: PRINCIPAL DIAGNOSIS CODE & PRESENT ON ADMISSION INDICATOR

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

Figure 3-35: FL67 Principal Diagnosis

- Not Titled in usual manner on UB (shaded background numbering).
- DX Required / POA Situational (Required for Hospitals)
  - Enter the patient's primary diagnosis, using an International Classification of Diseases (ICD-CM) code. For dates of service of 10/01/2015 and forward, use the appropriate ICD-10-CM code. For dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code. Present on admission (POA) indicator is required at this time.

NOTE: Inpatient claims with dates of service starting prior to 10/01/2015 and ending on or after 10/01/2015, should be billed with the appropriate ICD-10-CM code.

  - A primary diagnosis is required. Do not punctuate. Do not enter the decimal.
  - Providers, such as an Alternative Residential Facility, that do not have this code, please ask the member's physician or caseworker.
  - The code must be the full ICD diagnosis code, including all of the 3-7 alphanumeric characters where applicable. Where the proper code has fewer than 3-7 characters, the provider may not fill with zeroes.
  - Hospitals must use appropriate diagnosis codes when billing for serious reportable events.
  - Ambulance claims must include a diagnosis code. If unknown, use 780.99 "Other General Symptoms" for ICD-9. For ICD-10, use one of the following codes: R45.84 "anhedonia" or R68.89 "other general symptoms and signs".

FL 67 A-Q: OTHER DIAGNOSIS CODES & PRESENT ON ADMISSION INDICATOR

- Not Titled in usual manner on UB (shaded background lettering).
- Situational
  - Enter the ICD-9-CM or ICD-10-CM diagnosis code or codes that identify any additional conditions that co-existed at the time of admission, or any conditions that developed subsequently, and that affected the treatment received or the length of stay.

- Leave this blank if there are no additional diagnoses.
- Do not punctuate the codes.
- For dates of service of 10/01/2015 and forward, use the appropriate ICD-10-CM code. For dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code.

***NOTE**: Inpatient claims with dates of service starting prior to 10/01/2015 and ending on or after 10/01/2015, should be billed with the appropriate ICD-10-CM code.*

FL 68: RESERVED FOR ASSIGNMENT BY THE NUBC

- Not Labeled on UB
- Not Used

FL 69: ADMIT DX

- Situational (required on inpatient admissions).

FL 70: PATIENT REASON DX

- Required for all unscheduled outpatient visits. Unscheduled outpatient visits are defined as TOB 013x or 085x with a priority of admission of 1, 2 or 5 in FL14 and revenue codes of 045x, 0516, 0526 or 0762,
- The patient's reason for visit is not required for all scheduled outpatient encounters. It may be reported for scheduled visit, such as encounters for ancillary tests, when this data provides additional information to support medical necessity.

FL 71: PPS CODE

- Optional
  - Used by some providers to hold the DRG derived by their own Grouper.

FL 72: ECI

- Not Used

FL 73: RESERVED FOR ASSIGNMENT BY THE NUBC

- Not Labeled on UB
- Not Used

FL 74: PRINCIPAL PROCEDURE, CODE and DATE

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

Figure 3-36: FL74 Principal Procedure, Code and Date

- Situational (Required if Hospital-Inpatient with procedures).
  - Required on inpatient claims when a procedure was performed.
  - If not required (for example, on outpatient claims, do not send).
- If applicable, enter the code that identifies the principal procedure. Enter the date in six-digit format (MMDDYY).

- If the procedure is for sterilization or abortion, the principle procedure must agree with the diagnosis.

***NOTE**: Inpatient claims with dates of service starting prior to 10/01/2015 and ending on or after 10/01/2015, should be billed with the appropriate ICD-10-CM code. Outpatient claims should not be billed with dates of service that span the 10/01/2015 cutover date.*

FL 74 a-e: OTHER PROCEDURE, CODE and DATE

- Situational (Required if Hospital-Inpatient with procedures)
  - Required on inpatient claims when a procedure was performed.
  - If not required (for example, on outpatient claims, do not send).
- Enter the code identifying any other significant procedures other than the principal procedure. Enter the date in six-digit format (MMDDYY).

***NOTE**: Inpatient claims with dates of service starting prior to 10/01/2015 and ending on or after 10/01/2015, should be billed with the appropriate ICD-10-CM code. Outpatient claims should not be billed with dates of service that span the 10/01/2015 cutover date.*

FL 75: RESERVED FOR ASSIGNMENT BY THE NUBC

- Not Labeled on UB
- Not Used

FL 76: ATTENDING

76 ATTENDING		NPI	QUAL		
LAST			FIRST		
77 OPERATING		NPI	QUAL		
LAST			FIRST		
78 OTHER		NPI	QUAL		
LAST			FIRST		
79 OTHER		NPI	QUAL		
LAST			FIRST		

Figure 3-37: FL76 Attending

- Situational
  - Enter the National Provider Identifier (NPI), 2-digit qualifier (1G, Last Name and First Name of the attending physician, if applicable. This must be a Type 1 NPI.
  - An attending physician name and NPI is not required when the only service on the claim is emergency transportation, singular or Roster billing of Influenza or Pneumococcal Vaccinations and administration codes.
  - Self-Referred Mammography services can use either a Type 1 or Type 2 NPI when billed as the only services on the claim.
  - PNMI's that have completed full enrollment revalidation need to use a Type 1 NPI.
  - PNMI's that have not completed full enrollment revalidation can continue using a Type 2 NPI.

FL 77: OPERATING

- Situational

- Enter the National Provider Identifier (NPI), 2-digit qualifier (1G), Last Name and First Name of the operating physician, if applicable.

FL 78: OTHER

- Situational (referring providers)
  - Enter the National Provider Identifier (NPI), 2-digit qualifier (DN), Last Name and First Name of the other physician, if applicable.

FL 79: OTHER

- Situational (referring providers)
  - Enter the National Provider Identifier (NPI), 2-digit qualifier (DN), Last Name and First Name of the other physician, if applicable.

FL 80: REMARKS

80 REMARKS

Figure 3-38: FL80 Remarks

- Situational
  - Use Lines a–d for any necessary remarks. Use the recommended format for remarks.
  - UB-04 Manual for the recommended format.
  - If applicable, list “Medicare Replacement” or “Medicare Railroad” here.
  - When billing a Not Otherwise Classified (NOC) Code enter in FL80 (e.g. NOC, Line number: Description).

FL 81CC a-d:

- Required
  - Enter qualifier B3, and the billing provider’s taxonomy code.
  - Paper claims: If you have attachments, simply submit them with your claim.