



DIVISION OF MEDICAL SERVICES PROVIDER BULLETIN

Volume 29 Number 55

<http://www.dss.mo.gov/dms>

May 18, 2007

UB-04 (CMS 1450) Claim Form Transition

CONTENTS

- **UB-04 (CMS 1450) Claim Form**
 - **Inpatient Hospital Billing Instructions**
 - **Outpatient Billing Instructions**
 - **Hospital, Provider Type 01**
 - **Rural Health Clinic (Independent and Provider-Based), Provider Type 59**
 - **Home Health, Provider Type 58**
 - **Hospice, Provider Type 82**
-

UB-04 (CMS 1450) Claim Form

The Centers for Medicare & Medicaid Services (CMS), through recommendations of the National Uniform Billing Committee (NUBC), has mandated the use of the new UB-04 (CMS 1450) claim form. Missouri Medicaid will be requiring the new UB-04 claim form effective June 1, 2007.

The UB-92 will be accepted through the close of business on May 31, 2007. All claims, including resubmissions of past dates of service, must be submitted using the new UB-04 claim form starting June 1, 2007.

When ordering paper claims, the UB-92 will be available through May 18, 2007. Orders received on or after May 21, 2007 will be filled with the new UB-04 claim form.

Inpatient Hospital Billing Instructions

- The patient/recipient's Medicaid DCN or MC+ identification number may be shown in Field #8a but is required in Field #60.
- The location for reporting covered and non-covered days has changed to Fields #39-#41.
- Field #51 is no longer required.
- The Missouri Medicaid legacy provider number is required in Field #57.
- The National Provider Identifier (NPI) is optional, at this time, but may be reported in Field #56.
- The location for reporting the Internal Control Number (ICN) for documentation of timely filing has changed to Field #64.
- Field #81CC is designated for entering the Provider Taxonomy Code if applicable.

Field Number & Name	Requirements	Instructions for Completion
1. Provider Name, Address, Telephone Number	Required	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	Not Used	Leave blank
3. Patient Control Number	Optional	For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
4. Type of Bill	Required	<p>The required three digits in this code identify the following:</p> <ul style="list-style-type: none"> 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency <p>The allowed values for each of the digits found in the type of bill are listed below:</p> <p>Type of Facility: 1st digit: (1) Hospital</p> <p>Bill Classification: 2nd digit: (1) Inpatient (Including Medicare Part A) (2) Inpatient (Medicare Part B only)</p> <p>Frequency: 3rd digit: (1) Admit thru Discharge Claim (2) Interim Bill—First Claim (3) Interim Bill—Continuing Claim (4) Interim Bill—Last Claim</p>
5. Federal Tax Number	Optional	Enter the provider's federal tax number
6. Statement Covers Period ("From" and "Through" dates)	Required	<p>Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format.</p> <p>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.</p> <p>It should not include date(s) of recipient ineligibility. It should not include inpatient days that were not certified by HCE, such as preoperative days or days beyond the cease payment date.</p>

7. Unlabeled Field	Not Used	Leave blank.
8a. Patient's Name – ID	Optional	Enter the recipient's 8-digit Medicaid DCN or MC+ identification number. NOTE: The Medicaid DCN or MC+ identification number is <i>required</i> in Field #60.
8b. Patient's Name	Required	Enter the recipient's name in the following format: last name, first name, middle initial.
9. Patient's Address	Optional	Enter the recipient's full mailing address, including street number and name, post office box number or RFD, city, state, and zip code.
10. Patient's Birth Date	Optional	Enter the recipient's date of birth in MMDDYY format.
11. Patient's Sex	Optional	Enter the recipient's sex, "M" (male) or "F" (female).
12. Admission Date	Required	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 recipient's eligibility status on that date or HCE certification/denial of the admission date.
13. Admission Hour	Not used	Leave Blank.
14. Admission Type	Required	Enter the appropriate type of admission; the allowed values are: 1—Emergency 2—Urgent 3—Elective 4—Newborn
15. Source of Admission (SRC)	Required when applicable	If this is a transfer admission, complete this field. The allowed values are: 4—Transfer from a hospital 5—Transfer from a skilled nursing facility 6—Transfer from another health care facility
16. Discharge Hour	Not Used	Leave Blank.
17. Patient Status	Required	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

<p>17. Patient Status (cont.)</p>		<p>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)</p>
<p>18-24. Condition Codes</p>	<p>Required</p>	<p>Enter the appropriate two-character condition code(s). The values applicable to Medicaid are:</p> <p>C1—Approved as billed. Indicates the facility's Utilization Review authority has certified all days billed.</p> <p>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. <i>If C3 is entered, Field #35 must be completed.</i></p> <p>NOTE: Code C1 or C3 is <i>required</i>.</p> <p>A1—Healthy Children & Youth/EPSTD. 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.</p> <p>A4—Family Planning. If family planning services occurred during the inpatient stay, this condition code must be entered.</p>
<p>25-28. Condition Codes</p>	<p>Not Used</p>	<p>Leave blank.</p>
<p>29. Accident State</p>	<p>Not Used</p>	<p>Leave blank.</p>
<p>30. Unlabeled Field</p>	<p>Not Used</p>	<p>Leave blank.</p>
<p>31-34. Occurrence Codes & Dates</p>	<p>Required when applicable</p>	<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</p>

<p>31-34. Occurrence Codes & Dates (cont.)</p>		<p>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 not equal to the discharge date and the frequency code in Field #4 indicates this is the final bill.</p>
<p>35. Occurrence Span Code & Dates</p>	<p>Required when applicable</p>	<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>
<p>36. Occurrence Span Code & Dates</p>	<p>Not used</p>	<p>Leave blank.</p>
<p>37. Unlabeled Field</p>	<p>Not Used</p>	<p>Leave blank.</p>
<p>38. Responsible Party Name and Address</p>	<p>Not Used</p>	<p>Leave blank.</p>
<p>39-41. Value Codes & Amounts</p>	<p>Required</p>	<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 Enter the number of days shown in Field #6, minus the date of discharge. The discharge date is not a covered day and should not 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> <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.</p> <p>81—Noncovered Days If applicable, enter the number of noncovered days. Examples of noncovered days are those days for which the recipient is ineligible.</p> <p>NOTE: The total units entered in this field must be equal to the total accommodation units listed in Field #46.</p>

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42. Revenue Code	Required	<p>List appropriate accommodation revenue codes first in chronological order.</p> <p>Ancillary codes should be shown in numerical order.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>After all revenue codes are shown, skip a line and list revenue code 001, which represents total charges.</p>
43. Revenue Description	Not Used	Leave Blank.
44. HCPCS/Rates/ HIPPS Code	Required	Enter the daily room and board rate to coincide with accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use separate lines to report each rate.
45. Service Date	Not Used	Leave Blank.
46. Service Units	Required	<p>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.</p> <p>NOTE: The number of units in Fields #39-#41 must equal the number of units in this field.</p>
47. Total Charges	Required	<p>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.</p> <p>NOTE: The room rate multiplied by the number of units must equal the charge entered for room accommodation(s).</p>

48. Noncovered Charges	Required when applicable	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	Not Used	Leave blank.
50. Payer Name	Required	The primary payer is always listed first. If the recipient has insurance, the insurance plan is the primary payer and "Medicaid" is listed last.
51. Health Plan ID	Not Used	Leave blank.
52. Release of Information Certification Indicator	Not Used	Leave blank.
53. Assignment of Benefits Certification Indicator	Not Used	Leave blank.
54. Prior Payments	Required when applicable	Enter the amount the hospital received toward payment of this bill from all other health insurance companies. Payments must correspond with the appropriate payer entered in Field #50. <i>Do not enter a previous Medicaid payment, Medicare payment or copay amount received from the patient in this field.</i>
55. Estimated Amount Due From Patient	Not Used	Leave blank.
56. National Provider Identifier (NPI)	Optional	Enter the hospital's 10-digit NPI number.
57. Other Provider ID	Required	Enter the hospital's 9-digit Missouri Medicaid legacy provider number.
58. Insured's Name	Required when applicable	Complete if the insured's name is different from the recipient's name.
59. Patient's Relationship to the Insured	Not Used	Leave blank.
60. Insured's Unique ID	Required	Enter the recipient's 8-digit Medicaid DCN or MC+ identification number. If insurance was indicated in Field #50, enter the insurance number to correspond with the order shown in Field #50.

61. Insurance Group Name	Required when applicable	If insurance is shown in Field #50, state the name of the group or plan through which the insurance is provided to the insured.
62. Insurance Group Number	Required when applicable	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.
63. Treatment Authorization Code	Required when applicable	For claims requiring certification, enter the unique 7-digit certification number supplied by HCE.
64. Document Control Number	Required when applicable	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	Optional	If recipient is employed, the employer's name may be entered here.
66. Diagnosis & Procedure Code Qualifier	Not Used	Leave blank.
67. Principal Diagnosis Code	Required	Enter the complete 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-D. Other Diagnosis Codes	Required when applicable	Enter any additional diagnosis codes that have an effect on the treatment received or the length of stay.
67. E-Q. Other Diagnosis Codes	Not Used	Leave blank.
68. Unlabeled Field	Not Used	Leave blank.
69. Admitting Diagnosis	Not Used	Leave blank.
70. Patient's Reason for Visit	Not Used	Leave blank.
71. Prospective Payment System (PPS) Code	Not Used	Leave blank.
72. External Cause of Injury Code (E Code)	Not Used	Leave blank.
73. Unlabeled Field	Not Used	Leave blank.
74. Principal Procedure Code & Date	Required when applicable	Enter the full ICD-9-CM procedure code of the principal surgical procedure. The date on which the procedure was performed must be shown. Only month and day are required.

74. A-E. Other Procedure Codes & Dates	Required when applicable	Identify and date any other procedures that may have been performed.
75. Unlabeled Field	Not Used	Leave blank.
76. Attending Provider Name & Identifiers	Required	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, Missouri Medicaid legacy provider number or UPIN number.
77. Operating Provider Name & Identifiers	Required when applicable	Physician's NPI is optional. Enter the operating physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, Missouri Medicaid legacy provider number or UPIN number.
78-79. Other Provider Name & Identifiers	Required when applicable	Physician's NPI is optional. Enter the physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, Missouri Medicaid legacy provider number or UPIN number.
80. Remarks	Required when applicable	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.
81CC. Code-Code Field	Optional	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.

Outpatient Billing Instructions

- Includes instructions for Outpatient Hospital, Independent and Provider-Based Rural Health Clinics, Hospice and Home Health providers. Instructions apply to all providers unless otherwise indicated.
- The patient/recipient's Medicaid DCN or MC+ identification number may be shown in Field #8a but is required in Field #60.
- Field #51 is no longer required.
- The Missouri Medicaid legacy provider number is required in Field #57.
- The National Provider Identifier (NPI) is optional, at this time, but may be reported in Field #56.
- The location for reporting the Internal Control Number (ICN) for documentation of timely filing has changed to Field #64.
- Field #81CC is designated for entering the Provider Taxonomy Code, if applicable.

Field Number & Name	Requirements	Instructions for Completion
1. Provider Name, Address, Telephone Number	Required	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	Not Used	Leave blank
3. Patient Control Number	Optional	For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
4. Type of Bill	Required	<p>The required three digits in this code identify the following:</p> <p>1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency</p> <p>Outpatient Hospital: The valid type of bill is "131."</p> <p>Independent RHC: The valid type of bill is "715."</p> <p>Provider-Based RHC: The valid type of bill is "711."</p> <p>Hospice: The valid type of bill is one of the following: 811—Freestanding 821—Provider affiliated</p> <p>Home Health: The type of facility must be a "3". Examples: 341, 331</p>
5. Federal Tax Number	Optional	Enter the provider's federal tax number or leave blank.
6. Statement Covers Period ("From" and "Through" dates)	Required when applicable	<p>Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format or leave blank.</p> <p>Hospice: Only one calendar month of services may be shown on a claim. <i>Required.</i></p> <p>Home Health: If the "From" and "Through" date is the same, the date of service need not be repeated in Field #45. If multiple dates are listed, each date must be listed individually in Field #45.</p>
7. Unlabeled Field	Not Used	Leave blank.

8a. Patient's Name – ID	Optional	<p>Enter the recipient's 8-digit Medicaid DCN or MC+ identification number.</p> <p>NOTE: The Medicaid DCN or MC+ identification number is <i>required</i> in Field #60.</p>
8b. Patient's Name	Required	<p>Enter the recipient's name in the following format: last name, first name, middle initial.</p>
9. Patient's Address	Optional	<p>Enter the recipient's full mailing address, including street number and name, post office box number or RFD, city, state, and zip code.</p>
10. Patient's Birth Date	Optional	<p>Enter the recipient's date of birth in MMDDYY format.</p>
11. Patient's Sex	Optional	<p>Enter the recipient's sex, "M" (male) or "F" (female).</p>
12. Admission Date	Not Used	<p>Leave blank.</p>
13. Admission Hour	Not Used	<p>Leave blank.</p>
14. Admission Type	Required when applicable	<p>Outpatient Hospital: Leave blank unless this claim is for an emergency room service. If so, enter Admission Type 1. Condition Code AJ also must be listed in field 24 to exempt the patient from the \$3.00 cost sharing amount for the service.</p> <p>All other providers: Leave blank.</p>
15. Source of Admission (SRC)	Not Used	<p>Leave blank.</p>
16. Discharge Hour	Not Used	<p>Leave blank.</p>
17. Patient Status	Required when applicable	<p>Hospice: Enter "50" hospice home or "51" hospice medical facility (which includes nursing facilities).</p> <p>All other providers: Leave blank.</p>
18-24. Condition Codes	Required when applicable	<p>Enter the applicable two-character condition code. The values are:</p> <p>A1—HCY/EPSDT If this service is the result of an HCY referral or is an HCY related visit, enter this condition code.</p> <p>Home Health & Hospice: "A1" is the only valid value. Do <i>not</i> use "A4" or "AJ".</p> <p>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 with non-family planning services.</p>

18-24 Condition Codes (cont.)		<p>AJ—Payer Not Responsible for Co-payment.</p> <p>Outpatient Hospital: If visit is the result of an emergency or therapy services are provided, then condition code must be entered to exempt the patient from the \$3.00 cost sharing amount.</p> <p>Independent & Provider-Based RHC: Do <i>not</i> use the "AJ" Condition Code.</p>
25-28. Condition Codes	Not Used	Leave blank.
29. Accident State	Not Used	Leave blank.
30. Unlabeled Field	Not Used	Leave blank.
31-34. Occurrence Codes & Dates	Required when applicable	<p>If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim:</p> <ul style="list-style-type: none"> 01—Auto Accident 02—No Fault 03—Accident/Tort Liability 04—Accident/Employment Related 05—Other Accident 06—Crime Victim <p>Home Health: When billing physical, occupational or speech therapy for the initial certification period this field is required. In the first part of this field, enter the appropriate code from the following list::</p> <ul style="list-style-type: none"> 35—Physical Therapy 44—Occupational Therapy 45—Speech Therapy <p>Enter the beginning date of the initial Plan of Care in the second half of the field for each code identified.</p> <p>This field is required only in the above situations.</p> <p>When billing for skilled nurse visits, home health aide or any service which has been prior authorized, regardless of the approval of the prior authorization, leave blank.</p>
35-36. Occurrence Span Code & Dates	Not Used	Leave blank.
37. Unlabeled Field	Not Used	Leave blank.
38. Responsible Party Name and Address	Not Used	Leave blank.
39-41. Value Codes & Amounts	Not Used	Leave blank.

<p>42. Revenue Code</p>	<p>Required when applicable</p>	<p>Outpatient Hospital: 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).</p> <p>Independent RHC: Enter revenue code 0521.</p> <p>Provider-Based RHC: Optional field.</p> <p>Hospice: Enter one of the following Revenue Codes: 0651 - Hospice/Routine Home Care 0652 - Hospice/Continuous Home Care 0655 - Hospice/Inpatient Respite Care 0656 - Hospice/General Inpatient Care 0658 - Hospice/Room & Board-Nursing Facility</p> <p>Home Health: Leave blank.</p>
<p>43. Revenue Description</p>	<p>Required when applicable</p>	<p>Outpatient Hospital: Leave blank.</p> <p>Independent RHC: Enter "Rural Health Clinic Encounter". <i>Required.</i></p> <p>Provider-Based RHC: Optional field.</p> <p>Hospice: Leave blank.</p> <p>Home Health: Enter the description of the service, such as skilled nurse visit, supplies, etc. <i>Required.</i></p>
<p>44. HCPCS/Rates/HIPPS Code</p>	<p>Required</p>	<p>Enter the CPT or HCPCS procedure code(s) and any applicable modifier.</p> <p>Outpatient Hospital: Only enter the procedure code if for services <i>other</i> than outpatient facility charges listed in Field #42.</p> <p>Rural Health Clinics: If the service is a full or partial EPSDT/HCY screening, diagnosis code V20.2 must be shown as the primary diagnosis in Field #67.</p> <p>NOTE: Surgical procedures performed in the RHC must be entered in Field #74.</p>

<p>44. HCPCS/Rates/ HIPPS Code (cont.)</p>		<p>Independent RHC: Enter HCPCS procedure code T1015. If the service is a full or partial EPSDT/HCY screening, enter HCPCS procedure code T1015EP. The 5-digit EPSDT/HCY CPT screening code must be shown in Field #74. V20.2 must be shown as the primary diagnosis code in Field #67.</p> <p>If it should become necessary to provide services on the same day which constitute a separate encounter in accordance with Medicare guidelines, skip one line and show a second encounter code. A completed Certificate of Medical Necessity must be attached to the UB-04 claim.</p> <p>Hospice: Only enter the procedure code if billing for <u>physician services</u>.</p> <p>Home Health: Enter the appropriate HCPCS procedure code. Refer to Section 19 of the Home Health manual for list of covered procedure codes. Bill one visit per detail line.</p>
<p>45. Service Date</p>	<p>Required</p>	<p>Enter the date of service on each line billed in MMDDYY format.</p> <p>Hospice: When billing a revenue code for multiple days of service on a single line, enter the first day being billed.</p> <p>Note: Each date on which continuous home care (revenue code 0652) is provided must be billed on a separate line. Charges for continuous home care for multiple days <i>cannot</i> be combined on one line.</p>
<p>46. Service Units</p>	<p>Required</p>	<p>Enter the number of units for each procedure, revenue code or supply items (Home Health) billed.</p> <p>NOTE: If no entry is made, the system autoplugs a unit of "1".</p> <p>Outpatient Hospital: Facility codes 0450, 0459, 0490, 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."</p>

46. Service Units (cont.)		<p>Hospice: Enter the number of units for each revenue code billed. The last date of service is automatically calculated.</p> <p>NOTE: 0652 is billed by hourly units. Each line must include charges for only one day.</p>
47. Total Charges	Required	<p>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.</p> <p>Independent RHC: If a second encounter is listed, skip one line and enter the total of these charges. The total charge amount must correspond with the "Total Charges" in Field #47. In all cases, whether there are single or multiple encounters, enter "Total Charges" for each date of service.</p> <p>NOTE: When two encounters occur on the same date for the same patient, a completed Certificate of Medical Necessity detailing the need for each visit must be submitted with the claim.</p>
48. Noncovered Charges	Not Used	Leave blank.
49. Unlabeled Field	Not Used	Leave blank.
50. Payer Name	Required	The primary payer is always listed first. If the recipient has insurance, the insurance plan is the primary payer and "Medicaid" is listed last.
51. Health Plan ID	Not Used	Leave blank.
52. Release of Information Certification Ind.	Not Used	Leave blank.
53. Assignment of Benefits Certification Ind.	Not Used	Leave blank.
54. Prior Payments	Required when applicable	<p>Enter 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.</p> <p><i>Do not enter a previous Medicaid payment, Medicare payment or copay amount received from the patient in this field.</i></p>
55. Estimated Amount Due From Patient	Not Used	Leave blank.
56. National Provider Identifier (NPI)	Optional	Enter the provider's 10-digit NPI number.

57. Other Provider ID	Required	Enter the provider's 9-digit Missouri Medicaid legacy provider number.
58. Insured's Name	Required when applicable	Complete if the insured's name is different from the recipient's name.
59. Patient's Relationship to the Insured	Not Used	Leave blank.
60. Insured's Unique ID	Required	Enter the recipient's 8-digit Medicaid or MC+ identification number. If insurance was indicated in Field #50, enter the insurance number to correspond with the order shown in Field #50.
61. Insurance Group Name	Required when applicable	If insurance is shown in Field #50, state the name of the group or plan through which the insurance is provided to the insured.
62. Insurance Group Number	Required when applicable	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.
63. Treatment Authorization Code	Not Used	Leave blank.
64. Document Control Number	Required when applicable	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 from the remittance advice that documents that the claim was previously filed and denied within the one-year limit.
65. Employer Name	Optional	If recipient is employed, the employer's name may be entered here.
66. Diagnosis & Procedure Code Qualifier	Not Used	Leave blank.
67. Principal Diagnosis Code	Required	<p>Enter the complete ICD-9-CM diagnosis code for the condition for which the services were provided.</p> <p>Remember to code to the highest level of specificity shown in the current version of the ICD-9-CM diagnosis code book.</p> <p>Rural Health Clinics: If the services are family planning, they must be entered on a separate claim form using the appropriate family planning diagnosis code in range V25 through V25.9.</p> <p>If the service is an EPSDT/HCY screening, V20.2 must be shown as the principal diagnosis.</p>

67. A-D. Other Diagnosis Codes	Required when applicable	Enter any additional diagnosis codes that have an effect on the treatment received. Rural Health Clinics: Submit a separate claim form for services with family planning diagnoses.
67. E-Q. Other Diagnosis Codes	Not Used	Leave blank.
68. Unlabeled Field	Not Used	Leave blank.
69. Admitting Diagnosis	Not Used	Leave blank.
70. Patient's Reason For Visit	Not Used	Leave blank.
71. Prospective Payment System (PPS) Code	Not Used	Leave blank.
72. External Cause of Injury Code (E-Code)	Not Used	Leave blank.
73. Unlabeled Field	Not Used	Leave blank.
74. Principal Procedure Code & Date	Required when applicable	Enter the full CPT surgical procedure code. The date on which the procedure was performed must be stated. Only month and day are required. Hospice: If billing for <u>physician services</u> and a surgical procedure was performed, enter the CPT code. The date on which the procedure was performed must be stated. Home Health: Leave blank. Rural Health Clinics: The surgical procedures reflected in this field must have been performed at the RHC. Independent RHC: If the service is an EPSDT/HCY screening, the 5-digit CPT screening code must be entered in this field. Diagnosis code V20.2 must be shown as the principal diagnosis in Field #67.
74. A-E. Other Procedure Codes & Dates	Required when applicable	Identify and date any other procedures that may have been performed. Hospice: If billing for <u>physician services</u> and more than one surgical procedure was performed, state the additional procedure codes and the dates performed. Home Health: Leave blank.

75. Unlabeled Field	Not Used	Leave Blank.
76. Attending Provider Name & Identifiers	Required when applicable	<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, Missouri Medicaid legacy provider number or UPIN number.</p> <p>Hospice: <i>Required.</i></p>
77. Operating Provider Name & Identifiers	Optional	<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, Missouri Medicaid legacy provider number or UPIN number.</p>
78-79. Other Provider Name & Identifiers	Required when applicable	<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, Missouri Medicaid legacy provider number or UPIN number.</p> <p>If the recipient'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 Recipient (PI-118).</p> <p>Hospice: If billing for revenue code 0658, enter the legacy provider number for the nursing home in which the hospice patient resides. The nursing home room and board claim denies if this field is not completed.</p>
80. Remarks	Optional	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.
81CC. Code-Code Field	Optional	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.

Provider Bulletins are available on the DMS Web site at <http://dss.mo.gov/dms/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Web site at <http://dss.missouri.gov/dms/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via E-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One.

**Provider Communications Hotline
573-751-2896**

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