UB-04 Claim Form Instructions

The new claim form supports the use of the National Provider Identifier (NPI) number. In accordance with the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicaid will require the use of an NPI on all paper and electronic claims effective May 23, 2007. The NPI will replace existing Medicaid provider identifier numbers.

The table below follows the revised UB04 by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional, or conditional of the individual recipient's information.

An asterisk (*) indicates a new item or change in policy for Iowa Medicaid providers.

For electronic claim submitters, refer also to the EDI specifications for claim completion instructions.

Field Number	Field Name/Description	Instructions
1	(Untitled) - Provider name, address, and telephone number	**REQUIRED** – Enter the name, address, and phone number of the billing facility or service supplier. Note: the zip code must match the zip code confirmed during NPI verification or during enrollment. To view the zip code provided, return to imeservices.org.
2	(Untitled) - Pay-to Name, address, and Secondary Identification Fields	**SITUATIONAL** – Required when Pay-to name and address information is different than Billing Provider information in field 1.
3a	Patient Control Number	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 20 alpha/numeric characters and will be reflected on the remittance advice statement as "Medical Record Number."
3b	Medical Record Number	**OPTIONAL -** Enter the number assigned to the patient's medical/health record by the provider. This field is limited to 20 alpha/numeric characters and will be reflected on the remittance advice statement as "Medical Record Number" only if the field 3a is blank.

4	Type of Bill	**REQUIRED** – Enter a three-digit number consisting of one digit from each of the following categories in this sequence: First digit Type of facility Second digit Bill classification Third digit Frequency **Type of Facility** 1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice **Bill Classification** 1 Inpatient hospital, inpatient SNF or hospice (non-hospital based) 2 Hospice (hospital based) 3 Outpatient hospital, outpatient SNF or hospice (hospital based) 4 Hospital referenced laboratory services, home health agency, rehabilitation agency **Frequency** 1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim
5	Federal Tax Number	**OPTIONAL** – No entry required. NOTE: Changes to the Tax ID must be reported through IME Provider Services Unit at 1-800-338-7909 or 515-725-1004 (in Des Moines).
6	Statement Covers Period (From-Through)	**REQUIRED** – Enter the month, day, and year (MMDDYY format) under both the From and To categories for the period.
7 *	Untitled – Not used	**No entry required** **NOTE**: Covered and non-covered days are reported using value codes in fields 39a-41d.
8	Patient Name	**REQUIRED** – Enter the last name, first name, and middle initial of the member. Use the Medical Assistance Eligibility Card for verification.
9	Patient Address	**OPTIONAL** – Enter the full address of the member.
10	Patient's Birth Date	**OPTIONAL** – Enter the member's birth date as month, day, and year.
11	Sex	**REQUIRED** – Enter the patient's sex: "M" for male or "F" for female.
12	Admission Date	**REQUIRED** – Enter in MMDDYY format Inpatient, PMIC, and SNF – Enter the date of admission for inpatient services. Outpatient – Enter the dates of service. Home Health Agency and Hospice – Enter the date of admission for care. Rehabilitation Agency – No entry required.

13	Admission Hour	**REQUIRED FOR INPATIENT/PMIC/SNF** – The following chart consists of possible admission times and a corresponding code. Enter the code that corresponds to the hour the patient was admitted for inpatient care. Code Time – AM / Code Time - PM 00 12:00 - 12:59 Noon / 12 12:00 – 12:59 Midnight 01 1:00 - 1:59 / 13 1:00 – 1:59 02 2:00 - 2:59 / 14 2:00 – 2:59 03 3:00 - 3:59 / 15 3:00 – 3:59 04 4:00 - 4:59 / 16 4:00 – 4:59 05 5:00 - 5:59 / 17 5:00 – 5:59 06 6:00 - 6:59 / 18 6:00 – 6:59 07 7:00 - 7:59 / 19 7:00 – 7:59 08 8:00 - 8:59 / 20 8:00 – 8:59 09 9:00 - 9:59 / 21 9:00 – 9:59 10 10:00 - 10:59 / 22 10:00 – 10:59 11 11:00 - 11:59 / 23 11:00 – 11:59 99 Hour unknown
14	Type of Admission/Visit	**REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code corresponding to the priority level of this inpatient admission. 1 Emergency 2 Urgent 3 Elective 4 Newborn 9 Information unavailable
15	SRC (Source of Admission)	**REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code that corresponds to the source of this admission. 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Born inside the Hospital 6 Born outside of this hospital 7 Emergency room 8 Court/law enforcement 9 Information unavailable
16	DHR (Discharge Hour)	**REQUIRED FOR INPATIENT/PMIC/SNF** – The following chart consists of possible discharge times and a corresponding code. Enter the code that corresponds to the hour patient was discharged from inpatient care. See **Field 13, Admission Hour**, for instructions for accepted discharge hour codes.
17	STAT (Patient Status)	**REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code that corresponds to the status of the patient at the end of service. 01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to other short-term general hospital for inpatient care 03 Discharged/transferred to a skilled nursing facility (SNF) 04 Discharged/transferred to an intermediate

		care facility (ICF) 05 Discharged/transferred to another type of institution for inpatient care or outpatient services 06 Discharged/transferred to home with care of organized home health services 07 Left care against medical advice or otherwise discontinued own care 08 Discharged/transferred to home with care of home IV provider 10 Discharged/transferred to mental health care 11 Discharged/transferred to Medicaid certified rehabilitation unit 12 Discharged/transferred to Medicaid certified substance abuse unit 13 Discharged/transferred to Medicaid certified psychiatric unit 20 Expired 30 Remains a patient or is expected to return for outpatient services (valid only for non-DRG claims)
18-28	Condition Codes	**SITUATIONAL** – Enter corresponding codes to indicate whether or not treatment billed on this claim is related to any condition listed below. Up to seven codes may be used to describe the conditions surrounding a patient's treatment. **General** 01 Military service related 02 Condition is employment related 03 Patient covered by an insurance not reflected here 04 HMO enrollee 05 Lien has been filed **Inpatient Only** 80 Neonatal level II or III unit 81 Physical rehabilitation unit 82 Substance abuse unit 83 Psychiatric unit X3 IFMC approved lower level of care, ICF X4 IFMC approved lower level of care, SNF 91 Respite care **Outpatient Only** 84 Cardiac rehabilitation program 85 Eating disorder program 86 Mental health program 87 Substance abuse program 88 Pain management program 89 Diabetic education program 90 Pulmonary rehabilitation program 98 Pregnancy indicator – outpatient or rehabilitation agency **Special Program Indicator** A1 EPSDT A2 Physically handicapped children's program

		A3 Special federal funding A4 Family planning A5 Disability A6 Vaccine/Medicare 100% payment A7 Induced abortion – danger to life A8 Induced abortion – victim rape/incest A9 Second opinion surgery **Home Health Agency (Medicare not applicable)** XA Condition stable XB Not homebound XC Maintenance care XD No skilled service XH Supervisory visit with a mental health diagnosis
29	Accident State	**No entry required**
30	Untitled	**No entry required**
31-34	Occurrence Codes and Dates	**SITUATIONAL** – If any of the occurrences listed below are applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence. **Accident Related** 01 Auto accident 02 No fault insurance involved, including auto accident/other 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim **Insurance Related** 17 Date outpatient occupational plan established or reviewed 24 Date insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan was established or last reviewed A3 Medicare benefits exhausted **Other** 11 Date of onset
35-36	Occurrence Span Code and Dates	**No entry required**
37	Untitled	**No entry required.**
38	Untitled (Responsible party name and address)	**No entry required.**

39-41	Value Codes and Amounts	**SITUATIONAL** – Required if covered or non-covered days are included in the billing period. Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. 61 Location where service is rendered (HHA and Hospice) – for dates of service prior to 10/1/2005 80 Covered days 81 Non-covered days
42	Revenue Code	**REQUIRED** – Enter the appropriate corresponding revenue code for each item or service billed. Replace the "X" with a subcategory code, where appropriate, to clarify the code. Please note that all listed revenue codes are not payable by Medicaid. If you have questions concerning payment for a specific item/service, please call IME Provider Services at 1-800-338-7909 or 515-725-1004 (in Des Moines). **11X Room & Board – Private (medical or general)** Routine service charges for single bed rooms. Subcategories 0 General classifications 1 Medical/surgical/GYN 2 OB 3 Pediatric 4 Psychiatric 6 Detoxification 7 Oncology 8 Rehabilitation 9 Other **12X Room & Board – Semi-Private Two Bed (medical or general)** Routine service charges incurred for accommodations with two beds. Subcategories 0 General classifications 4 Sterile environment 7 Self care 9 Other **13X Room & Board – Semi-Private Three and Four Beds (medical or general)** Routine service charges incurred for accommodations with three and four beds. Subcategories 0 General classifications 4 Sterile environment 7 Self care 9 Other

		14X Private (deluxe) Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients. Subcategories 0 General classifications 4 Sterile environment 7 Self care 9 Other **15X Room & Board – Ward (medical or general)** Routine service charge for accommodations with five or more beds. Subcategories 0 General classifications 4 Sterile environment 7 Self care 9 Other **16X Other Room & Board** Any routine service charges for accommodations that cannot be included in the more specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing. Subcategories 0 General classifications 4 Sterile environment 7 Self care 9 Other **17X Nursery** Charges for nursing care to newborn and premature infants in nurseries. Subcategories 0 General classification 1 Newborn 2 Premature 5 Neonatal ICU 9 Other **18X Leave of Absence** Charges for holding a room or bed for a patient while the patient is temporarily away from the provider. Subcategory 5 Nursing home (for hospitalization) **20X Intensive Care** Routine service for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit. Subcategories 0 General classification 1 Surgical 2 Medical 3 Pediatric 4 Psychiatric

		6 Post ICU 7 Burn care 8 Trauma 9 Other intensive care **21X Coronary Care** Routine service charge for medical care provided to patients with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit. Subcategories 0 General classification 1 Myocardial infarction 2 Pulmonary care 3 Heart transplant 4 Post CCU 9 Other coronary care **22X Special Charges** Charges incurred during an inpatient stay or on a daily basis for certain services. Subcategories 0 General classification 1 Admission charge 2 Technical support charge 3 U.R. service charge 4 Late discharge, medically necessary 9 Other special charges **23X Incremental Nursing Charge Rate** Subcategories 0 General classification 1 Nursery 2 OB 3 ICU 4 CCU 9 Other **24X All Inclusive Ancillary** A flat rate charge incurred on either a daily or total stay basis for ancillary services only. Subcategories 0 General classification 9 Other inclusive ancillary **25X Pharmacy** Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies. Subcategories 0 General classification 1 Generic drugs 2 Nongeneric drugs 3 Take home drugs 4 Drugs incident to other diagnostic services 5 Drugs incident to radiology 6 Experimental drugs 7 Nonprescription 8 IV solutions 9 Other pharmacy

		26X IV Therapy Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists. Subcategories 0 General classification 1 Infusion pump 2 IV therapy/pharmacy services 3 IV therapy/drug/supply delivery 4 IV therapy/supplies 9 Other IV therapy **27X Medical/Surgical Supplies and Devices** **(also see 62X, an extension of 27X)** Charges for supply items required for patient care. Subcategories 0 General classification 1 Nonsterile supply 2 Sterile supply 3 Take home supplies 4 Prosthetic/orthotic devices 5 Pacemaker 6 Intraocular lens 7 Oxygen – take home 8 Other implants 9 Other supplies/devices **28X Oncology** Charges for the treatment of tumors and related diseases. Subcategories 0 General classification 9 Other oncology **29X Durable Medical Equipment (other than renal)** Charges for medical equipment that can withstand repeated use (excluding renal equipment). Subcategories 0 General classification 1 Rental 2 Purchase of new DME 3 Purchase of used DME 4 Supplies/drugs for DME effectiveness (home health agency only) 9 Other equipment **30X Laboratory** Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, be sure to indicate the code for each lab charge in UB-92 form field number 44. Subcategories 0 General classification 1 Chemistry 2 Immunology

		3 Renal patient (home) 4 Nonroutine dialysis 5 Hematology 6 Bacteriology and microbiology 9 Other laboratory **31X Laboratory – Pathological** Charges for diagnostic and routine laboratory tests on tissues and cultures. For outpatient services, indicate the CPT code for each lab charge in UB-92 form field number 44. Subcategories 0 General classification 1 Cytology 2 Histology 4 Biopsy 9 Other **32X Radiology – Diagnostic** Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting of radiographs and fluorographs. Subcategories 0 General classification 1 Angiocardiography 2 Arthrography 3 Arteriography 4 Chest x-ray 9 Other **33X Radiology – Therapeutic** Charges for therapeutic radiology services and chemotherapy required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances. Subcategories 0 General classification 1 Chemotherapy – injected 2 Chemotherapy – oral 3 Radiation therapy 5 Chemotherapy – IV 9 Other **34X Nuclear Medicine** Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. Subcategories 0 General classification 1 Diagnostic 2 Therapeutic 9 Other **35X CT Scan** Charges for computed tomographic scans of the head and other parts of the body.

		Subcategories 0 General classification 1 Head scan 2 Body scan 9 Other CT scans **36X Operating Room Services** Charges for services provided to patients by those specifically trained nursing personnel providing assistance to physicians in the performance of surgical and related procedures during and immediately following surgery. Subcategories 0 General classification 1 Minor surgery 2 Organ transplant – other than kidney 7 Kidney transplant 9 Other operating room services **37X Anesthesia** Charges for anesthesia services in the hospital. Subcategories 0 General classification 1 Anesthesia incident to radiology 2 Anesthesia incident to other diagnostic services 4 Acupuncture 9 Other anesthesia **38X Blood** Charges for blood must be separately identified for private payer purposes. Subcategories 0 General classification 1 Packed red cells 2 Whole blood 3 Plasma 4 Platelets 5 Leukocytes 6 Other components 7 Other derivatives (cryoprecipitates) 9 Other blood **39X Blood Storage and Processing** Charges for the storage and processing of whole blood. Subcategories 0 General classification 1 Blood administration 9 Other blood storage and processing **40X Other Imaging Services** Subcategories 0 General classification 1 Diagnostic mammography 2 Ultrasound 3 Screening mammography 4 Positron emission tomography 9 Other imaging services

		41X Respiratory Services Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure. Charges for other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases. Subcategories 0 General classification 1 Inhalation services 3 Hyperbaric oxygen therapy 9 Other respiratory services **42X Physical Therapy** Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities. Subcategories 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other occupational therapy/trial occupational therapy – rehab agency **43X Occupational Therapy** Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients. Subcategories 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other occupational therapy/trial occupational therapy – rehab agency **44X Speech – Language Pathology** Charges for services provided to those with impaired functional communication skills. Subcategories 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other speech-language pathology/trial speech therapy – rehab agency **45X Emergency Room** Charges for emergency treatment to those ill and injured persons requiring immediate

		unscheduled medical or surgical care. Subcategories 0 General classification 9 Other emergency room **46X Pulmonary Function** Charges for tests measuring inhaled and exhaled gases. Charges for the analysis of blood and for tests evaluating the patient's ability to exchange oxygen and other gases. Subcategories 0 General classification 9 Other pulmonary function **47X Audiology** Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function. Subcategories 0 General classification 1 Diagnosis 2 Treatment 9 Other audiology **48X Cardiology** Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests. Subcategories 0 General classification 1 Cardiac cath lab 2 Stress test 9 Other cardiology **49X Ambulatory Surgical Care** Charges for ambulatory surgery not covered by other categories. Subcategories 0 General classification 9 Other ambulatory surgical care **50X Outpatient Services** Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service. Subcategories 0 General classification 9 Other outpatient services **51X Clinic** Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive curative, rehabilitative, and education services on a scheduled basis to ambulatory patients. Subcategories 0 General classification 1 Chronic pain center

		2 Dental clinic 3 Psychiatric clinic 4 OB-GYN clinic 5 Pediatric clinic 9 Other clinic **52X Free-Standing Clinic** Subcategories 0 General classification 1 Rural health – clinic 2 Rural health – home 3 Family practice 9 Other free-standing clinic **53X Osteopathic Services** Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy. Subcategories 0 General classification 1 Osteopathic therapy 9 Other osteopathic services **54X Ambulance** Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention. **Note:** Ambulance is payable on the UB-04 form **only** in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form. Documentation of medical necessity must be provided for ambulance transport. The diagnosis/documentation must reflect that the patient was nonambulatory and the trip was to the nearest adequate facility. Subcategories 0 General classification 1 Supplies 2 Medical transport 3 Heart mobile 4 Oxygen 5 Air ambulance 6 Neonatal ambulance services 7 Pharmacy 8 Telephone transmission EKG 9 Other ambulance **55X Skilled Nursing (home health agency only)** Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the patient and achieving the medically desired result. Subcategories 0 General classification 1 Visit charge 2 Hourly charge 9 Other skilled nursing

		56X Medical Social Services (home health agency only) Charges for services such as counseling patients, interviewing and interpreting problems of social situations provided to patients on any basis. Subcategories 0 General classification 1 Visit charge 2 Hourly charge 9 Other medical social services **57X Home Health Aide (home health agency only)** Charges made by a home health agency for personnel primarily responsible for the personal care of the patient. Subcategories 0 General classification 1 Visit charge 2 Hourly charge 9 Other home health aide services **61X MRI** Charges for Magnetic Resonance Imaging of the brain and other body parts. Subcategories 0 General classification 1 Brain (including brainstem) 2 Spinal cord (including spine) 9 Other MRI **62X Medical/Surgical Supplies (extension of 27X)** Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures. Subcategories 1 Supplies incident to radiology 2 Supplies incident to other diagnostic services **63X Drugs Requiring Specific Identification** Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in UB-92 form field number 44. Subcategories 0 General classification 1 Single source drug 2 Multiple source drug 3 Restrictive prescription

		4 Erythropoietin (EPO), less than 10,000 units 5 Erythropoietin (EPO), 10,000 or more units 6 Drugs requiring detailed coding **64X Home IV Therapy Services** Charges for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy. Subcategories 0 General classification 1 Nonroutine nursing, central line 2 IV site care, central line 3 IV site/change, peripheral line 4 Nonroutine nursing, peripheral line 5 Training patient/caregiver, central line 6 Training, disabled patient, central line 7 Training, patient/caregiver, peripheral line 8 Training, disabled patient, peripheral line 9 Other IV therapy services **65X Hospice Services (hospice only)** Charges for hospice care services for a terminally ill patient if he or she elects these services in lieu of other services for the terminal condition. Subcategories 1 Routine home care 2 Continuous home care (hourly) 5 Inpatient respite care 6 General inpatient care 8 Care in an ICF or SNF **70X Cast Room** Charges for services related to the application, maintenance, and removal of casts. Subcategories 0 General classification 9 Other cast room **71X Recovery Room** Subcategories 0 General classification 9 Other recovery room **72X Labor Room/Delivery** Charges for labor and delivery room services provided by specially trained nursing personnel to patients. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite. Subcategories 0 General classification 1 Labor 2 Delivery 3 Circumcision

		4 Birthing center 9 Other labor room/delivery **73X EKG/ECG (electro-cardiogram)** Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments. Subcategories 0 General classification 1 Holter monitor 2 Telemetry 9 Other EKG/ECG **74X EEG (electro-encephalogram)** Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders. Subcategories 0 General classification 9 Other EEG **75X Gastro-Intestinal Services** Procedure room charges for endoscopic procedures not performed in the operating room. Subcategories 0 General classification 9 Other gastro-intestinal **76X Treatment or Observation Room** Charges for the use of a treatment room or for the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes (one unit per hour) on outpatient claims. Subcategories 0 General classification 1 Treatment room 2 Observation room 9 Other treatment/observation room **79X Lithotripsy** Charges for the use of lithotripsy in the treatment of kidney stones. Subcategories 0 General classification 9 Other lithotripsy **80X Inpatient Renal Dialysis** A waste removal process performed in an inpatient setting using an artificial kidney when the bodies own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

		Subcategories 0 General classification 1 Inpatient hemodialysis 2 Inpatient peritoneal (nonCAPD) 3 Inpatient continuous ambulatory peritoneal dialysis 4 Inpatient continuous cycling peritoneal dialysis (CCPD) 9 Other inpatient dialysis **81X Organ Acquisition (see 89X)** The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.) Subcategories 0 General classification 1 Living donor – kidney 2 Cadaver donor – kidney 3 Unknown donor – kidney 4 Other kidney acquisition 5 Cadaver donor – heart 6 Other heart acquisition 7 Donor – liver 9 Other organ acquisition **82X Hemodialysis – Outpatient or Home** A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Subcategories 0 General classification 1 Hemodialysis/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient hemodialysis **83X Peritoneal Dialysis – Outpatient or Home** A waste removal process, performed in an outpatient or home setting, necessary when the bodies own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue. Subcategories 0 General classification 1 Peritoneal/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient peritoneal dialysis **84X Continuous Ambulatory Peritoneal Dialysis** **(CCPD) – Outpatient or Home**

		A continuous dialysis process performed in an outpatient or home setting using the patient peritoneal membrane as a dialyzer. Subcategories 0 General classification 1 CAPD/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient CAPD **85X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home** A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night. Subcategories 0 General classification 1 CCPD/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient CCPD **88X Miscellaneous Dialysis** Charges for dialysis services not identified elsewhere. Subcategories 0 General classification 1 Ultrafiltration 2 Home dialysis aid visit 9 Miscellaneous dialysis other **89X Other Donor Bank (extension of 81X)** Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts – see 81X). Subcategories 0 General classification 1 Bone 2 Organ (other than kidney) 3 Skin 9 Other donor bank **92X Other Diagnostic Services** Subcategories 0 General classification 1 Peripheral vascular lab 2 Electromyelogram 3 Pap smear 4 Allergy test 5 Pregnancy test 9 Other diagnostic services **94X Other Therapeutic Services** Charges for other therapeutic services not otherwise categorized.

		Subcategories 0 General classification 1 Recreational therapy 2 Education/training 3 Cardiac rehabilitation 4 Drug rehabilitation 5 Alcohol rehabilitation 6 Complex medical equipment – routine 7 Complex medical equipment – ancillary 9 Other therapeutic services **99X Patient Convenience Items** Charges for items generally considered by the third party payers to be strictly convenience items, and, therefore, are not covered. Subcategories 0 General classification 1 Cafeteria/guest tray 2 Private linen service 3 Telephone/telegraph 4 TV/radio 5 Nonpatient room rentals 6 Late discharge charge 7 Admission kits 8 Beauty shop/barber 9 Other patient convenience items
43 *	Revenue Description	**SITUATIONAL** – Required if the provider enters a HCPCs "J-code" for a drug that has been administered. Enter the National Drug Code (NDC) that corresponds to the J-code entered in Field 44. NDC should be entered in NNNNN-NNNN-NN format. NO OTHER ENTRIES SHOULD BE MADE IN THIS FIELD.
44	HCPCS/Rates/HIPPS Rate Codes	**SITUATIONAL** – Outpatient Hospital – Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APG. Inpatient SNF – Enter the HCPCS code W0511 for ventilator dependent patients, otherwise leave blank. Home Health Agencies – Enter the appropriate HCPCS code from the prior authorization when billing for EPSDT related services. All Others – Leave blank. NOTE: RATES ARE NOT REQUIRED FOR PROCESSING AND SHOULD NOT BE ENTERED IN THIS FIELD.
45	Service Dates	**REQUIRED** – Outpatient - Enter the service date for outpatient service referenced in Field 42 or Field 44. Note that one entry is required for each date in which the service was performed
46	Service Units	**REQUIRED** –

		Inpatient – Enter the appropriate units of service for accommodation days. Outpatient – Enter the appropriate units of service provided per CPT/revenue code. (Batch-bill APGs require one unit = 15 minutes of service time.) Home Health Agencies – Enter the appropriate units for each service billed. A unit of service = a visit. Prior authorization private-duty nursing/personal care – one unit = an hour.
47	Total Charges	**REQUIRED** – Enter the total charges for each code billed. **Revenue Code "001" should be entered on line 23, and the entire claim should be summed and that amount placed on the last page of the claim on line 23, Field 47.**
48	Non-covered charges	**REQUIRED** – Enter the non-covered charges for each applicable code. The total of all non-covered charges for the claim should be entered on the last page of the claim on line 23, Field 48.
49	Untitled	**NOT USED.** NOTE: The "PAGE ___ OF ___" and CREATION DATE on line 23 should be reported on all pages of the UB-04
50 A-C	Payer Identification	**REQUIRED** – Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill.
51 A-C	Health Plan ID	Not required for Medicaid
52 A-C	Release of Information Certification Indicator	**NOT REQUIRED** – By submitting the claim, the provider has agreed to all information on the back of the claim form, including release of information
53 A-C	Assignment of Benefits Certification Indicator	**NO ENTRY REQUIRED**
54 A-C	Prior Payments	**SITUATIONAL** – If applicable, enter the amount paid by a payer other than Medicaid. Do not enter previous Medicaid payments.
55 A-C	Estimated Amount Due From Patient	**NO ENTRY REQUIRED**
56	National Provider ID (NPI)	**REQUIRED** - Effective May 23, 2007. Enter the NPI of the Billing entity.
57	Other Provider ID	**REQUIRED** through May 22, 2007. Enter the seven-digit Medicaid (legacy) number on the line that corresponds to Medicaid in Field 50. This entry will no longer be required effective May 23, 2007
58 A-C	Insured's name	**REQUIRED** – Enter Medicaid member's last name, first name, and middle initial on the line that corresponds to Medicaid from Field 50
59 A-C	Patient's Relationship to Insured	**NO ENTRY REQUIRED**
60 A-C	Insured's unique ID	**REQUIRED-** Enter the member's Medicaid identification number found on the *Medical Assistance Eligibility Card.* It should consist of seven digits followed by a letter, i.e., 1234567A
61	Group Name	**NO ENTRY REQUIRED**
62 A-C	Insurance Group Number	**NO ENTRY REQUIRED**

63 *	Treatment Authorization Code	**SITUATIONAL** – Enter prior authorization number if applicable. ***NOTE: This field is no longer used to report the MEDIPASS referral. Refer to Field 79 to enter the MEDIPASS referral Note: Lock-In moved to a Field 78***
64	Document Control Number (DCN	**NO ENTRY REQUIRED**
65	Employer name	**NO ENTRY REQUIRED**
66	Diagnosis and Procedure code Qualifier (ICD Version Indicator)	**NO ENTRY REQUIRED.** Medicaid only accepts ICD-9 codes
67	Principal Diagnosis Code	**REQUIRED** – Enter the ICD-9-CM code for the principal diagnosis.
67 A-Q	Other Diagnosis Codes	**SITUATIONAL** – Enter the ICD-9-CM codes for diagnosis, other than principal, for the additional diagnosis.
68	Untitled	**NO ENTRY REQUIRED**
69	Admitting Diagnosis	**SITUATIONAL** – Inpatient Hospital – The admitting diagnosis is required.
70 A-C *	Patient's Reason for Visit	**SITUATIONAL** – Patient's Reason for Visit is required for all un-scheduled outpatient visits for outpatient bills.
71	PPS (Prospective Payment System) Code	**NO ENTRY REQUIRED**
72	ECI (External Cause of Injury codes	**NO ENTRY REQUIRED**
73	Untitled	**NO ENTRY REQUIRED**
74	Principal Procedure Code and Date	**SITUATIONAL** – For the principal surgical procedure, enter the ICD-9-CM procedure code and surgery date, when applicable.
74 A-E	Other Procedure Codes and Dated	**SITUATIONAL** – For additional surgical procedures, enter the ICD-9-CM procedure codes and surgery dates.
75	Untitled	**NO ENTRY REQUIRED**
76	Attending Provider name and identifiers (including NPI)	**REQUIRED** – Inpatient Hospital, SNF, Rehab Agency, Home Health Agency, and PMIC – Through May 22, 2007 enter the UPIN or seven-digit Iowa Medicaid provider number (aka Legacy) for the treating physician. If entering the legacy, qualifier "1D" must precede the entry. If entering the UPIN, qualifier "1G" must precede the entry. THESE ENTRIES (legacy and/or UPIN) SHOULD NOT BE IN THE NPI FIELD. Effective May 23, 2007 the 10digit NPI number of the treating physician will be required. The last name, first initial, and discipline are also needed. The treating physician has primary responsibility for the patient's care from the start of hospitalization. Outpatient – Through May 22, 2007 enter the UPIN or seven-digit Iowa Medicaid provider number of the physician referring the patient to the hospital. Effective May 23, 2007 the 10digit NPI number of the referring physician will be required. This area should not be completed if the primary physician did not give the referral.

		On outpatient billings, do not show treating physician information in this area.
77	Operating Provider Name and Identifiers (including NPI)	**SITUATIONAL** –Through May 22, 2007 enter the UPIN number of physician performing the principal procedure, if applicable. If a UPIN number is unavailable, enter the physician's seven digit Iowa Medicaid provider number (aka Legacy). If entering the legacy, qualifier "1D"must precede the entry. If entering the UPIN, qualifier "1G" must should precede the entry. THESE ENTRIES (legacy and/or UPIN) SHOULD NOT BE IN THE NPI FIELD. Effective May 23, 2007 the 10digit NPI number of the physician performing the principal procedure will be required. The last name, first initial, and discipline are also needed.
78 *	Other provider name and identifiers (including NPI)	**SITUATIONAL** – Enter the NPI of the member's lock-in provider if the member is on lock-in. If entering the legacy, qualifier "1D"must precede the entry. THESE ENTRIES SHOULD NOT BE ENTERED IN THE NPI FIELD
79 *	Other provider name and identifiers (including NPI)	**SITUATIONAL** – Enter the MEDIPASS Referring NPI. If entering the legacy, qualifier "1D"must precede the entry. THESE ENTERIES SHOULD NOT BE ENTERED IN THE NPI FIELD
80 *	Remarks	**SITUATIONAL** – When applicable enter one of the following: - Not a Medicare Benefit - Resubmit (list the original filing date) - Member is Retro-Eligible and NOD is attached (notice of decision).
81 *	Code-Code fields	**REQUIRED** – Enter taxonomy code associated with the NPI of the billing entity (Field 56). Precede taxonomy code with qualifier "B3" (healthcare provider taxonomy code). Note: the taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the taxonomy code provided, return to imeservices.org.