

**MARYLAND MEDICAL
ASSISTANCE PROGRAM
UB-04
BILLING INSTRUCTIONS
FOR
FREESTANDING DIALYSIS FACILITY SERVICES
As of March 10, 2009**

Rev. 03/09/09

UB04 Instructions
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The uniform bill for institutional providers is known as the UB-04 and is the replacement for the UB-92 form. Starting July 30, 2007 all institutional paper claims must use the UB-04; the UB-92 will no longer be acceptable after this date.

The instructions are organized by the corresponding boxes or "Form Locators" on the paper UB-04 and detail only those data elements required for Medical Assistance (MA) billing. The manual also includes a crosswalk from NUBC to help you understand the changes from the UB-92 to the UB-04.

The UB-04 is a uniform institutional bill suitable for use in billing multiple third party liability (TPL) payers. When submitting the above claims, complete all items required by each payer who is to receive a copy of the form.

Free-standing dialysis facilities will bill on a UB-04. Services that are to be billed on the UB-04 are dialysis services furnished on an outpatient basis and provided by a freestanding dialysis facility. These services include chronic hemodialysis, chronic peritoneal dialysis, self dialysis, home dialysis and home dialysis training and laboratory tests as specified in COMAR 10.09.22.05E and .07G(6) of the regulations for free-standing dialysis facility services.

The Maryland Medicaid statute of limitations for timely claim submission is as follows: Invoices for services rendered at free-standing dialysis facilities must be received within twelve (12) months of the date of service on the claim. If a claim is received within the 12 month limit but rejected, resubmission will be accepted within 60 days of the date of rejection or within 12 months of the date of service, whichever is longer. If a claim is rejected because of late receipt, the patient may not be billed for that claim. If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted.

For any claim initially submitted to Medicare and for which services have been approved or denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

All third-party resources, such as insurance or Worker's Compensation, should be billed first and payment either received or denied before the Medical Assistance Program may be billed for any portion not covered. However, if necessary to meet the 12-month deadline for receipt of the claim(s), the Medical Assistance Program may be billed first and then reimbursed if the third-party payer makes payment later.

Invoices may be typed or printed. If printed, the entries must be legible. Do not use pencil or a red pen to complete the invoice. Otherwise, payment may be delayed or the claim rejected.

Completed invoices are to be mailed to the following address:

Maryland Medical Assistance Program
Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

Adjustments should be completed when a specific bill has been issued for a specific provider, patient, payer, insured and “statement covers period” date(s); the bill has been **paid**; and a supplemental payment is needed. To submit an adjustment, a provider should complete a DHMH-4518A, Adjustment Form and mail that form to the address below:

Maryland Medical Assistance Program
Adjustment Section
P.O. Box 13045
Baltimore, MD 21203

PLEASE NOTE: WHEN COMPLETING THE UB-04 CLAIM FORM FOR DIALYSIS SERVICES, THE ENTIRE CLAIM MAY NOT EXCEED 50 LINES. SHOULD THE CLAIM EXCEED 50 LINES, IT WILL DENY.

1	2	3a PAT. CNTRL #	4 TYPE OF BILL
5 PATIENT NAME	6 PATIENT ADDRESS	7	8
9 BIRTHDATE	10 SEX	11 DATE	12
13	14	15	16
17	18	19	20
21	22	23	24
25	26	27	28
29	30	31	32
33	34	35	36
37	38	39	40
41	42	43	44
45	46	47	48
49	50	51	52
53	54	55	56
57	58	59	60
61	62	63	64
65	66	67	68
69	70	71	72
73	74	75	76
77	78	79	80
81	82	83	84
85	86	87	88
89	90	91	92
93	94	95	96
97	98	99	100

The instructions that follow are keyed to the form locator number and headings on the UB-04 form.

FL 01 **Billing Provider Name, Address, and Telephone Number**

Required. Enter the name and service location of the provider submitting the bill.

Line 1 Enter the provider name filed with the Medical Assistance Program.

Line 2 Enter the street address to which the invoice should be returned if it is rejected due to provider error.

Line 3 Enter the City, State & full nine-digit ZIP Code

Line 4 Telephone, Fax, County Code (desirable but optional)

NOTE: Checks and remittance advices are sent to the provider's address as it appears in the Program's provider master file.

FL 02 **Pay-to Name and Address**

Leave Blank – Internal Use Only

FL 03a **Patient Control Number**

Required. Enter the patient's unique alphanumeric control number assigned to the patient by the freestanding dialysis facility. The facility must assign each patient a unique number. A maximum of 20 positions will be returned on the remittance advice to the provider.

FL 03b **Medical/Health Record Number**

Optional. Enter the medical/health record number assigned to the patient by the freestanding dialysis facility when the provider needs to identify for future inquiries the actual medical record of the patient. Up to 24 positions may be entered.

FL 04 **Type of Bill**

Required. Enter the 4-digit code indicating the specific type of bill. For freestanding dialysis facilities, use the bill type 0721. All four digits are required to process a claim.

FL 05 **Federal Tax Number**

Not required. The number assigned to the provider by the federal government for tax reporting purposes. The format is: NN-NNNNNNNN; 10 positions (include hyphen). For electronic claims, do not report the hyphen.

FL 06 **Statement Covers Period (From - Through)**

Required. Enter the “From” and “Through” dates covered by the services on the invoice (MMDDYY). Your facility may not bill for two separate months on one claim form.

NOTE A: For all services received on a single day both the “From” and “Through” dates will be the same. Continuing treatment must be billed on a day-to-day basis.

NOTE B: Medicare Part B claims should include the “From” and “Through” dates as indicated on the Medicare payment listing or EOMB.

FL 07 **NOT USED – Reserved for Assignment by NUBC**

FL 08a **Patient Name – Identifier**

Not required. Patient’s ID (if different than the subscriber/insured’s ID).

FL 08b **Patient Name**

Required. Enter the patient’s name as it appears on the Medical Assistance card: last name, first name, and middle initial. (Please print this information clearly.)

FL 09, 1a-2e **Patient Address**

Optional. Enter the patient’s complete mailing address, as follows:

Line 1a -- Enter the patient address – Street number and name; if no street address, enter the P.O. Box number

Line 2b -- Enter the patient address – City

Line 2c -- Enter the patient address – State

Line 2d -- Enter the patient address – Zip

Line 2e -- Enter the patient address –Country Code (Report if other than USA)

FL 10 **Patient Birth Date**

Required. Enter the month, day, and year of birth (MMDDYYYY). Example: 11223333

FL 11 **Patient Sex**

Not required. Enter the patient’s sex as recorded at admission, outpatient service, or start of care.

M – Male F – Female U – Unknown

FL 12 **Admission/Start of Care Date**
Not required for freestanding dialysis facilities.

FL 13 **Admission Hour**
Not required for freestanding dialysis facilities.

FL 14 **Priority (Type) of Visit**
Not required for freestanding dialysis facilities.

FL 15 **Source of Referral for Admission or Visit**
Not required for freestanding dialysis facilities.

FL 16 **Discharge Hour**
Not required for freestanding dialysis facilities.

FL 17 **Patient Discharge Status**
Not required for freestanding dialysis facilities.

FL 18-28 **Condition Codes**
Not required for freestanding dialysis facilities for the Maryland Medical Assistance Program. A provider may use the condition code if using them for other billers. The Maryland Medical Assistance Program will not deny claims if the condition code is present.

FL 29 **Accident State.**
Not required for freestanding dialysis facilities.

FL 30 **Reserved for Assignment by NUBC - Not Used**

FL 31-34 a b **Occurrence Codes and Dates**
Required when there is an Occurrence Code that applies to this claim. Enter the code and associated date defining a significant event relating to this bill that may affect payer processing. Enter all dates as MMDDYY.

The Occurrence Span Code fields can be utilized to submit additional Occurrence Codes when necessary by leaving the THROUGH date blank in FL 35-36. As a result, up to 12 Occurrence Codes may be reported.

Report Occurrence Codes in alphanumeric sequence (numbered codes precede alphanumeric codes) in the following order: FL 31a, 32a, 33a, 34a, 31b, 32b, 33b, 34b. If there are Occurrence Span Code fields available, fields 35a FROM, 36a FROM, 35b FROM and 36b FROM may then be used as an overflow. After all of these fields are exhausted, FL 81 (Code-Code field) can be used with the appropriate qualifier (A2) to report additional codes and dates (see FL 81 for additional information).

Enter the appropriate codes and dates from the attached table.

See Attachment One for the Code Structure – Occurrence Codes & Dates matrix.

FL 35-36a b **Occurrence Span Codes and Dates**
Not required for freestanding dialysis facilities.

FL 37 **NOT USED**
FL 38 **Responsible party name and address**

Not required for freestanding dialysis facilities.

FL 39-41 a-d Value Codes and Amounts

Not required for freestanding dialysis facilities for the Maryland Medical Assistance Program. A provider may use the condition code if using them for other billers. The Maryland Medical Assistance Program will not deny claims if the condition code is present.

WHEN COMPLETING THE UB-04 FOR DIALYSIS SERVICES, THE ENTIRE CLAIM MAY NOT EXCEED 50 LINES. SHOULD THE CLAIM EXCEED 50 LINES, IT WILL DENY.

FL 42 Revenue Codes

Required. Line 1-23. Enter the appropriate four-digit numeric revenue code from the attached Dialysis Revenue Code Matrix for freestanding dialysis facility services. When reporting the revenue code, if needed, report the corresponding HCPCS code for the service rendered. The appropriate revenue code must be entered to explain each charge in FL 47. If multiple services are provided on the same day for like services, that is, those with the same HCPCS, the provider should combine the like services for each day and report the date along with the number of units provided, as well as the revenue code. Services provided on different days should be listed separately along with the date of service, units, and revenue code.

The 23rd line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

To assist in bill review, revenue codes should always be listed in ascending numeric sequence, by date of service (outpatient). The exception is Revenue Code 0001, which is used on paper claims only and is reported on Line 23 of the last page of the claim.

See Attachment Two for the Dialysis Revenue Code Matrix.

FL 43 National Drug Code (NDC) – Medicaid Drug Rebate Reporting

NDC is required for freestanding dialysis facility claims when reporting the revenue code 0250. The NDC is required on all dialysis claims submitted on or after September 1, 2008, for dates of service on or after July 1, 2008.

Format:

- 1) Report the NDC qualifier of “N4” in the first two positions, left justified.
- 2) The 11 character NDC number should immediately follow the NDC qualifier and should be reported in the 5-4-2 format. Do not report hyphens.
- 3) The Unit of Measure Qualifier should immediately follow the last character of the NDC. The Unit of Measure Qualifiers are listed below:

F2 – International Unit
GR – Gram
ML – Milliliter

UN - Unit

- 4) Immediately following the Unit of Measurement Qualifier, is the Unit Quantity with a floating decimal for fractional units limited to three (3) digits to the right of the decimal point. Any spaces unused for the quantity field are left blank.
- 5) A maximum of seven (7) positions to the left of the floating decimal may be reported.
- 6) When reporting a whole number, do not key the floating decimal.
- 7) When reporting fractional units, you must enter the decimal as part of the entry.

Sample NDC:

Whole Number Unit:

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	5	6	7		
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--	--

Fractional Unit:

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--

General Notes:

- 1) Do not enter a revenue description in the revenue description field; the description field is 24 characters in length and is where the NDC will be placed (refer to the sample NDC above).
- 2) Do not enter a space between the qualifier and the NDC.
- 3) Do not enter hyphens or spaces within the NDC number.
- 4) The NDC Number submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.
- 5) Enter the NDC unit of measurement code and numeric quantity administered to the patient.
- 6) If the NDC reported is not eligible for the rebate, the line item charges will be denied.

Reporting Multiple NDC's:

You may report multiple line items of revenue codes and associated NDC numbers as follows:

- 1) Each line item must reflect the revenue code 0250 with the appropriate HCPCS;
- 2) Each line item must reflect a valid NDC per the NDC format; and
- 3) Each NDC reported must be unique or the revenue code line item will deny as a duplicate against the revenue code and NDC line item that matched it.

Reporting Compound Drugs:

When reporting compound drugs, a maximum of five (5) lines are allowed and should be reported in the following manner:

- 1) On the first line for the compound drug, report the revenue code (0250), the valid NDC per the NDC format, the appropriate HCPCS for the drug that is administered, the total number of units administered for all drugs in the compound and the total charge for all of the drugs that are in the compound.
- 2) For each subsequent line, report only the NDC and the appropriate HCPCS related to the compound drug.
- 3) If one line for the compound drug denies, the entire compound drug will deny.

Example of Reporting Compound Drugs

for dollars, 2 positions for cents.

Total (Summary) Charges

Required on Line 23 of the final claim page using Revenue Code 0001.

The 23rd line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

Revenue code 0001 is not used on electronic transactions; report the total claim charge in the appropriate data segment/field according to the electronic companion guides.

FL 48 Non-Covered Charges
Not required for freestanding dialysis facilities.

FL 49 Reserved for Assignment by NUBC

FL 50 a,b,c Payer Name
Optional. First line, 50a is the Primary Payer Name. Second line, 50b is the Secondary Payer Name. Third line, 50c is the Tertiary Payer Name. Multiple payers should be listed in priority sequence according to the priority in which the provider expects to receive payment from these payers.

NOTE: If other payers listed, then Medicaid should be the last entry in this field.

FL 51 a,b,c Health Plan Identification Number
Not required. When other health plans are known to potentially be involved in paying this claim. The number used by the health plan to identify itself. Report the HIPAA National Plan Identifier when it becomes mandated; otherwise report the (legacy/proprietary) number (i.e., whatever number used has been defined between trading partners).

FL 52 a,b,c Release of Information Certification Indicator
Not required for free standing dialysis facilities.

FL 53 a,b,c Assignment of Benefits Certification Indicator
Not required for free standing dialysis facilities.

FL 54 a,b,c Prior Payments - Payer
Required when the indicated payer has paid an amount to the provider towards this bill. Enter the amount the provider has received (to date) by the health plan toward payment of this bill. **DO NOT REPORT MEDICARE PRIOR PAYMENTS IN THIS FIELD.**

FL 55 a,b,c Estimated Amount Due
Not required for freestanding dialysis facilities.

FL 56 National Provider Identifier (NPI) – Billing Provider
Required. The unique identification number assigned to the provider submitting the bill; NPI is the 10-digit national provider identifier. Beginning on the Medical Assistance NPI compliance

date of July 30, 2007, when the Billing Provider is an organization health care provider, the organization health care provider will report its NPI or its subpart's NPI in FL 56.

Note: Organizational health care providers must continue to report proprietary legacy identifiers necessary for Maryland Medicaid to identify the Billing Provider entity in FL 57 Lines a-c.

FL 57 Other (Billing) Provider Identifier - Legacy

Required. A unique identification number assigned to the provider submitting the bill by the health plan. Enter the Maryland Medicaid Legacy 9-digit provider number.

The UB04 does not use a qualifier to specify the Other (Billing) Provider Identifier. Use this field to report other provider identifiers as assigned by the health plan (as indicated in FL50 Lines a-c).

FL 58 a,b,c Insured's Name
Not required for freestanding dialysis facilities.

FL 59 a,b,c Patient Relationship to Insured
Not required for freestanding dialysis facilities.

FL 60 a,b,c Insured's Unique ID
Required. Enter the Medical Assistance number of the insured as it appears on the Medical Assistance card. If billing for a newborn, you must use the newborn's Medical Assistance number.

If there are other insurance numbers shown, such as Medicare, then the Medicaid identification number should appear last in the field.

REMINDER:

Providers may verify a patient's current Medical Assistance eligibility by calling the Eligibility Verification System/Interactive Voice Response (EVS/IVR) line:

Toll-Free Number for the entire State: 1-866-710-1447

WebEVS: Providers may verify a patient's current Medical Assistance eligibility by using the new web-based eligibility services available for providers who are enrolled in EMedicaid. To access this service, click on: www.emdhealthchoice.org

FL 61 a,b,c Insured's Group Name
Not required for freestanding dialysis facilities.

FL 62 a,b,c Insured's Group Number
Not required for freestanding dialysis facilities.

FL 63 a,b,c Treatment Authorization Code
Not required for freestanding dialysis facilities.

FL 64 a-c **Document Control Number (DCN)**
Not required for freestanding dialysis facilities.

FL 65 **Employer Name (of the Insured)**
Not required for freestanding dialysis facilities.

FL 66 **Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**

Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported.

FL 67 **Principal Diagnosis Code and Present on Admission Indicator**

Principal Diagnosis Code

Required. Enter the 7-digit ICD-9-CM code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

Always code to the most specific level possible, but do not enter any decimal points when recording codes on the UB-04.

Follow the official guidelines for ICD reporting. Refer to the Official ICD-9-CM Guidelines for Coding and Reporting for additional information.

The ICD-9-CM codes will be used for inpatient and outpatient services.

NOTE A: The principal diagnosis code will include the use of “V” codes. The “E” codes are not acceptable for principal diagnosis.

NOTE B: When billing for newborn, must use newborn diagnosis codes.

Present on Admission (POA) Indicator – Not Required: All Fields

- The 8th digit of FL 67 - Principal Diagnosis (shaded area), and each of the secondary diagnosis fields (FL 67A-Q).
- The 8th digit of FL 72, External Cause of Injury (ECI) (3 fields on the form).

FL 67 a-q **Other Diagnosis Codes – Not required.**

Enter the ICD-9-CM diagnoses codes corresponding to all conditions that co-exist at the time of treatment, that develop subsequently, or that affect the treatment received.

Enter the appropriate ICD-9-CM diagnosis code (co-morbidity) in FL 67a that determines the DRG selected.

Completion of FL 67 c-q is currently optional as our data processing system will accept one principal and three co-existing diagnoses.

NOTE A: Other diagnoses codes will permit the use of “V” codes and “E” codes where appropriate.

FL 68 **Reserved for Assignment by NUBC**

FL 69 **Admitting Diagnosis**
Not required for freestanding dialysis facilities.

FL 70 a,b,c **Patient’s Reason for Visit Code**
Not required for freestanding dialysis facilities.

FL 71 **Prospective Payment System (PPS) Code**

Not required. The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.

FL 72 a-c **External Cause of Injury Code (ECI or E-Code)**
Not required for freestanding dialysis facilities.

FL 73 **Reserved for Assignment by NUBC - Not required.**

FL 74 **Principal Procedure Code and Date**

Enter the principal procedure code performed during the billing period as shown in the patient’s medical record. In determining which of the several procedures the principal procedure is, the following criteria should be applied in sequence.

- a. The principal procedure is one which was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication; or
- b. The principal procedure is that procedure most related to the principal diagnosis.

This code structure must be ICD-9-CM when billing inpatient or outpatient services.

Whenever a procedure is provided a date must be supplied - format is “MMDDYY”.

FL 74 a-e **Other Procedure Codes and Dates**

Enter the ICD-9-CM codes and dates identifying all significant procedures, other than the principal procedure that was performed during the billing period covered by this bill.

This code structure must be ICD-9-CM when billing inpatient or outpatient services.

Whenever a procedure is provided, a date must be supplied, format is “MMDDYY”.

Completion of FL74 c-e are optional as our data processing system will only accept the principal

code and date and two additional procedure codes and dates.

FL 75 **Reserved for Assignment by NUBC**

FL 76 **Attending Provider Name and Identifiers**

Required. The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

Line 1 Outpatient: Enter the 10-digit NPI number assigned to the freestanding dialysis facility.

Line 2 Attending Physician Name
Not Required. Last/First

FL 77 **Operating Physician Name and Identifiers**
Not required for freestanding dialysis facilities.

FL 78 **Other Provider (Individual) Names and Identifiers**
Not required for freestanding dialysis facilities.

FL 79 **Other Provider (Individual) Names and Identifiers**
Not required for freestanding dialysis facilities.

FL 80 **Remarks - Not required**

FL 81 a-d **Code-Code Field**
Not required for freestanding dialysis facilities.

Attachment One:

Code Structure – Occurrence Codes & Dates Matrix:		
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the hospital from any insurer.
25	Date Benefits Terminated by Primary Payer	Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.

Attachment Two:

Dialysis Revenue Code Matrix

Medicaid's previous procedure code	Medicaid's revenue codes for UB 04	Description of service	
W0300	0821	Hemodialysis, staff assisted	
W0300	0821	Hemodialysis, self care in unit	
W0300	0821	Hemodialysis, back up in facility	
W0330	0820	Hemodialysis, self care training	
W0310	0825	Hemodialysis, home care	
W0310	0829	Hemodialysis, home care 100%	
W0331	0830	Peritoneal self care training	
W0305	0831	Peritoneal staff assisted	
W0320	0841	CAPD, staff assisted	
W0320	0841	CAPD, self care unit	
W0320	0841	CAPD, home care	
W0320	0841	CAPD, back up in facility	
W0335	0840	CAPD, self care training	
W0320	0849	CAPD, home care 100%	
W0325	0851	CCPD, staff assisted	
W0325	0851	CCPD, self care in unit	
W0325	0851	CCPD, home care	
W0325	0851	CCPD, back up in facility	
W0340	0850	CCPD, self care training	
W0325	0859	CCPD, home care 100%	
W0350	0270*	Description of supplies	Appropriate HCPCS
W0370	0250**	NDC	Appropriate HCPCS

***For supplies that are used to administer drugs at a free standing dialysis facility, on the UB 04 bill for the supplies with the revenue code of 0270, along with the appropriate HCPCS. Please remember to include the number of administrations in the units field on the UB 04 in FL 46.**

****For drugs that are administered at the free standing dialysis facility, bill on the UB 04 with the revenue code 0250. The National Drug Code (NDC) that is associated with the drug that is being administered must be present and formatted correctly (see FL 43) and the appropriate HCPCS for the drug that is being administered must be reported on the UB 04. Remember to include the number of units administered on the UB 04 in FL 46.**