CLAIMS FILING

Claims for End Stage Renal Disease (ESRD) services must be filed by electronic claims submission 837I or on the UB 04 claim form.

There are limits placed on the number of line items that are allowed when filing claims. ESRD claims must include National Drug Code (NDC) information for all physician administered drugs identified with an alphanumeric Healthcare Common Procedure Coding System (HCPCS) code and billed with a revenue code. Two-page claims are acceptable for ESRD services.

Epoetin Alfa (EPO)

Payment made to providers billing the Epogen treatments individually is based on the total units of EPO as indicated in value code 40A. The total payment for EPO is indicated on the first treatment claim line for the first service date, and the remainder of the EPO treatment dates will appear on the RA with zero (0 dollar) payments and edit code 978 (payment adjusted to zero, call help desk).

Special documentation is not required with the claim for Medicaid only recipients requiring 10,000 units or more of EPO per administration; however, documentation should be maintained with the recipient's records.

When claims for Epogen services are billed with HR634 or HR635, payment is indicated on the first line and all other lines are paid at zero. This does not allow providers to submit adjustments if the claims are paid incorrectly. Therefore, providers must submit a void and allow the successfully voided claim to process and appear on the remittance advice before re-submitting the corrected claim for processing. In order to void more than one claim line, a separate UB04 form is required for each claim line as each claim line as a different Internal Control Number.

Epogen must be reported using procedure code Q4081. No other HCPCS code will be accepted for Epogen.

The units of service field for EPO must be reported based on the HCPCS code dosage description as is done with all other physician administered drugs. For example: The HCPCS code description for Q4081 is Injection, Epoetin Alfa, 100 units (for ESRD on dialysis). If the provider administers 12,400 units of EPO on that date of service, 124 should be entered as the service units in FL 46.

Instructions for Completing the UB04 Form

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	**Required.** Enter the name and address of the facility.	
2	Pay to Name/Address/ID	**Situational.** Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	**Optional.** Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record #	**Optional.** Enter patient's medical record number (up to 24 characters*)*	
4	Type of Bill	**Required.** Enter the appropriate 3-digit code as follows: *1st Digit - Type of Facility* 7 *2nd Digit - Classification* 2 = Inpatient Medicaid and Medicare Part B only *3rd Digit – Frequency Definition* 1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim. That is 721 for claims, 727 for adjustments, or 728 for voids	
5	Federal Tax No.	**Optional.**	

Locator #	Description	Instructions	Alerts
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	**Required.** Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	Leave blank.	
8	Patient's Name	**Required.** Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	**Required**. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birth Date	**Required.** Enter the recipient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	**Required**. Enter sex of the recipient as: M = Male F = Female U = Unknown	
12	Admission Date	**Required.** Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	Leave blank.	
14	Type Admission	Leave blank.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	
17	Patient Status	Leave blank.	
18-28	Condition Codes	Leave blank.	
29	Accident State	Leave blank.	
30	Unlabeled Field	Leave blank.	

Locator #	Description	Instructions	Alerts
31-34	Occurrence Codes/Dates	Leave blank.	
35-36	Occurrence Spans (Code and Dates)	Leave blank.	
37	Unlabeled	Leave blank.	
38	Responsible Party Name and Address	Optional.	
39-41	Value Codes and Amounts	**Required**. Enter the following Value Code (listed below) when billing for Epogen (EPO): 49 = Hematocrit Reading – Enter the patient's hematocrit reading to justify administering more than 10,000 units of EPO. Enter 49 in the "Code" field. Enter the hematocrit reading in the "Amount" field, right justified to the left of the dollar/cents delimiter. Enter "00" in the "Cents" portion of the "Amount" section of the field. 68 = EPO Drug – Enter the total number of units of EPO administered and/or supplied relating to the billing period. Enter 68 in the "Code" field. Enter the total number of EPO units administered in the "Amount" field. Report amount in whole units right-justified to the left of the dollar/cents delimiter. Enter "00" in the "Cents" portion of the "Amount" section of the field. **No other value codes are required for processing ESRD claims; if optional codes are entered, they must be entered after 49 and 68, above.**	EPO billing: Providers must enter Value Codes 49 and 68 first in the Value Code fields; other Value Codes are optional, and if they are entered, they must be entered below 49 and 68.
42	Revenue Code	**Required**. Enter the applicable revenue code(s) which identifies the service provided. Codes must be valid. Revenue Code 001 must be entered in Form Locator 42 line 23 with corresponding total charges entered in Form Locator 47 line 23.	

Locator #	Description	Instructions	Alerts

43	Revenue Description	**Required for services other than physician-administered drugs.** Enter the narrative description of the corresponding Revenue Code in Form Locator 42.
		
		Required for physician-administered drugs. **ESRD** Claims reporting Epogen or other physician-administered drugs must contain the following:
		
		Report the N4 qualifier in the first two positions, left-justified.
		
		Immediately following the N4 qualifier, report the 11 character National Drug Code number in the 5-4-2 format (no hyphens).
		
		Immediately following the last digit of the NDC (no delimiter), report the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:
		
		     F2 -International Unit
		     GR-Gram
		     ML-Milliliter
		     UN- Unit
		
		Immediately following the Unit of Measurement Qualifier, report the unit quantity in **NDC UNITS** with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
		
		Any spaces unused for the quantity are left blank.
		
		Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible.
		
		The Description Field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.
		
		N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 . 5 6 7
		
		Two page claims are accepted for ESRD claims. Use "Page ___ of ___" on line 23 as needed for two-page claims. Enter "Page <u>1</u> of <u>2</u>" or "Page <u>2</u> of <u>2</u>" as appropriate.
			ESRD claims must include NDC information for all physician-administered drugs identified with an alphanumeric HCPCS code and billed with Revenue Codes 634, 635, and 636. The NDC data must be entered in FL 43 as indicated in the adjacent "Instructions" field.

Locator #	Description	Instructions	Alerts
44	HCPCS/Rates HIPPS Code	**Required.** Enter the appropriate 5-digit Procedure Code. **For physician-administered drug services:** Claims reporting Physician Administered Drugs identified with alphanumeric HCPCS codes must contain the following: Enter the corresponding HCPCS Code for the NDC reported in FL 43.	Epogen must be reported using procedure code Q4081. No other HCPC codes will be accepted for Epogen.
45	Service Date	**Required.** Enter the appropriate service date (MMDDYY) for each service. **Required.** Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	The CREATION DATE replaces the Date of Provider Representative Signature

Locator #	Description	Instructions	Alerts
46	Units of Service	**Required.** Enter the appropriate unit(s) for the procedure code entered on the same line in FL 44.	Providers should no longer enter "1" in the units of service field (FL 46) for EPO. The units of service for EPO (Q4081) must now be reported based on the HCPC code dosage description as is done with all other physician-administered drugs. For example: The HCPC code description for Q4081 is: Injection, Epoetin Alfa, 100 units (for ESRD on dialysis). If a provider administers 12,400 units of EPO on that date of service, then 124 should be entered as the service units in FL 46.
47	Total Charges	**Required.** Enter the charges pertaining to the related Revenue Codes. (Enter total charges on Line 23 of Form Locator 47 corresponding with Revenue Code 001 in Form Locator 42.)	
48	Non-Covered Charges	**Leave Blank.**	
49	Unlabeled Field (National)	**Leave Blank.**	

Locator #	Description	Instructions	Alerts
50-A,B,C	Payer Name	**Situational.** Enter insurance plans other than Medicaid on Lines "A", "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is **required**. The Medically Needy Spend down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	**Situational.** Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is **required**.	
52-A,B,C	Release of Information	**Optional.**	
53-A,B,C	Assignment of Benefits Cert. Ind.	**Optional.**	
54-A,B,C	Prior Payments	**Situational.** Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0.00' in this field.	
55-A,B,C	Estimated Amt. Due	**Optional.**	
56	NPI	**Required.** Enter the provider's National Provider Identifier (NPI)	The 10-digit NPI must be entered here.
57	Other Provider ID	**Required.** Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	The 7-digit Medicaid Provider Number MUST be entered here.

Locator #	Description	Instructions	Alerts
58-A,B,C	Insured's Name	**Required.** Enter the recipient's name as it appears on the Medicaid ID card in 58A. **Situational**: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	
59-A,B,C	Patient's Relationship to Insured	**Situational.** If insurance coverage other than Medicaid applies, enter the recipient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	

Locator #	Description	Instructions	Alerts
60-A,B,C	Insured's Unique ID	**Required.** Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A. **Situational.** If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	ONLY the 6-digit code should be entered for commercial and Medicare HMO′s in this field. DO NOT enter dashes, hyphens, or the word TPL in the field. NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE
62-A,B,C	Insured's Group No. (Medicaid not Primary)	**Situational.** If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured′s number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	**Leave blank.**	

Locator #	Description	Instructions	Alerts

64-A,B,C	Document Control Number	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A.
		
		Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.
		
		Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:
		
		Adjustments
		  01 = Third Party Liability Recovery
		  02 = Provider Correction
		  03 = Fiscal Agent Error
		  90 = State Office Use Only – Recovery
		  99 = Other
		
		Voids
		  10 = Claim Paid for Wrong Recipient
		  11 = Claim Paid for Wrong Provider
		  00 = Other
			To adjust or void more than one claim line, a separate UB-04 form is required for each claim line since each line has a different internal control number.
			
			When claims for EPOGEN services are billed with HR634 or HR635, payment is indicated on the first line and all other lines are paid at zero.
			
			This does not allow providers to submit adjustments if the claims are paid incorrectly.
			
			Therefore, providers must submit a VOID and allow the successfully voided claim to process and appear on the remittance advice before re-submitting the corrected claim for processing.

65-A,B,C	Employer Name	**Situational.** If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	**Leave blank.**	

Locator #	Description	Instructions	Alerts
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	**Required.** Enter the ICD-9-CM code for the principal diagnosis. **Situational.** Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. Note: Use **the most specific and accurate ICD-9-CM Diagnosis Code. A 3-digit Diagnosis Code is to be used only if it is not further subdivided. Where 4-digit subcategories and/or 5-digit sub-classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.**	ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after10/1/15. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
68	Unlabeled	**Leave blank.**	
69	Admitting Diagnosis	**Optional.** Enter the admitting Diagnosis Code.	Refer to field locator 67.
70	Patient Reason for Visit	**Leave blank.**	
71	PPS Code	**Leave blank.**	
72- A B C	ECI (External Cause of Injury)	**Leave blank.**	
73	Unlabeled.	**Leave blank.**	
74 74 a – e	Principal Procedure Code / Date Other Procedure Code / Date	**Leave blank.**	

Locator #	Description	Instructions	Alerts
75	Unlabeled	Leave **blank**.	
76	Attending	**Required. Enter the name and NPI number of the attending physician.**	This field must be completed.
77	Operating	Leave **blank**.	
78	Other	Leave **blank**.	
79	Other	Leave **blank**.	
80	Remarks	**Situational.** Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave **blank**.	

Signature is not required on the UB-04

SAMPLE END STAGE RENAL DISEASE CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

1 DIALYSIS OF LOUISIANA	2			3a PAT. CNTL # 1111111		4 TYPE OF BILL
987 CORN ST.				b. MED. REC. # 111111111111		723
ANYWHERE, LA 71111				5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 090715	7

8 PATIENT NAME a DOE, JOHN	9 PATIENT ADDRESS a 1235 ANYSTREET
b	b ANYWHERE c LA d 71111 e

| 10 BIRTHDATE 010143 | 11 SEX M | 12 DATE 120513 ADMISSION 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | 18 19 20 21 22 23 CONDITION CODES 24 25 26 27 28 | 29 ACDT STATE | 30 |

| 31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 OCCURRENCE SPAN FROM THROUGH |

38		39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
	a	49 30 00	68 37200 00	
	b			
	c			
	d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	635	N412345678901 UN 1234.56	Q0481	090215	124	124 00		1
2	635	N412345678901 UN 1234.56	Q0481	090415	124	124 00		2
3	635	N412345678901 UN 1234.56	Q0481	090715	124	124 00		3
4	636	N454321432121 UN 4.56	J1760	090715	1	50 00		4
5	821	HEMODIALYSIS COMPOIST	90935	090215	1	130 00		5
6	821	HEMODIALYSIS COMPOIST	90935	090415	1	130 00		6
7	821	HEMODIALYSIS COMPOIST	90935	090715	1	130 00		7

SAMPLE

EXAMPLE OF ICD 9

23 PAGE 1 OF 1	CREATION DATE 091015	TOTALS → 812 00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
A MEDICAID				TPL		57 1234567
B				PAYMENT IF		OTHER
C				APPLICABLE		PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN		1234567890123	TPL CARRIER	
B			CODE IF	
C			APPLICABLE	

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

66 DX 5851	67 A B C D E F G H	68
	I J K L M N O P Q	

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73
74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 1298765432
				LAST ADAMS FIRST JANE
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL
				LAST FIRST
80 REMARKS	81CC a			78 OTHER NPI QUAL
	b			LAST FIRST
	c			79 OTHER NPI QUAL
	d			LAST FIRST

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

SAMPLE END STAGE RENAL DISEASE CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)

Adjustments/Voids for Free Standing ESRD Facilities

Only a paid claim can be adjusted or voided. When completing the UB04 for adjustments or voids, only one previously paid claim line can be adjusted or voided per UB 04. Providers should enter bill type 727 for an adjustment or bill type 728 for a void.

The following three items are required in block 84 for an adjustment:

- Enter "A" for adjustment;

- Enter the previously paid Internal Control Number (ICN) found on the paid RA for the line item; and

- Enter one of the following reason codes:

  - 01 – TPL Recovery;
  - 02 – Provider Correction;
  - 03 – Fiscal Agency Error; or
  - 99 – Other.

The following three items are required in block 84 for a void:

- Enter "V" for void;

- Enter the previously paid Internal Control Number (ICN) found on the paid RA for the line item; and

- Enter one of the following reason codes:

  - 10 – Claim Paid for Wrong Patient;
  - 11 – Claim Paid to Wrong Provider; or
  - 00 – Other.

Note: For a Medicare adjustment/void, there will be only one ICN. Only one adjustment/void claim form will be completed. For straight Medicaid claims, providers should file adjustment/void claims by line

SAMPLE END STAGE RENAL DISEASE CLAIM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

SAMPLE END STAGE RENAL DISEASE CLAIM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)