1		2		3a PAT. CNTL #		4 TYPE OF BILL
				b. MED. REC. #		
				5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

| 8 PATIENT NAME | a | 9 PATIENT ADDRESS | a | | | | c | d | | e |
| b | | | b | | | | | | | |

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

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

38			39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a				
	b				
	c				
	d				

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

PAGE ___ OF ___   CREATION DATE   TOTALS ➡

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

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

| 63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME |
| | | |

| 66 DX | 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 QUAL
				LAST FIRST
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   NLCF-UB04-1   APPROVED OMB NO. 0938-0997   OCR/Original   **NUBC** National Uniform Billing Committee 24394604   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-04 Instructions

Hospital, nursing facility (NF), and intermediate care facility (ICF) providers must use the National Uniform Billing Committee (NUBC) approved UB-04 paper claim form or the equivalent Electronic Data Interchange (EDI) 837 X12 transaction when requesting payment for medical services and supplies provided under the Kansas Medical Assistance Program (KMAP).

Claims can be submitted on the KMAP provider secure portal, as an electronic 837 X12 transaction, through Provider Electronic Solutions (PES), or on an original, red ink UB-04 paper claim form.

Claims not meeting the following requirements will be returned to the provider.

- Claims submitted that do not adhere to the instructions indicated below.

- The Kansas Modular Medicaid System (KMMS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed or if the data is not in alignment within the fields.

- KanCare (managed care) claims should be submitted to the appropriate KanCare managed care organization (MCO). **KMAP will not forward paper claims to the MCOs on behalf of the provider.**

The fiscal agent does not furnish the paper UB-04 claim forms to providers. The form must be obtained from a claim form supplier, such as the one listed below.

Advantage Business Forms
211 Southwest 6th
Topeka, KS 66603
785-235-6868

Send completed paper claim to:
Kansas Medical Assistance Program
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571

UB-04 Instructions

Nursing Facility Only

If the stay meets Medicare-coverage criteria, Medicare reimburses the NF for the first 20 days and there is no coinsurance or deductible. If after day 20 the stay is still covered by Medicare, days 21 to 100 are reimbursed by Medicare for all but the Medicare coinsurance and deductible. This coinsurance and deductible can be billed to KMAP on the UB-04 (electronic or paper) using your National Provider Identifier (NPI) number and indicating the type of bill (TOB) 21X, 65X, or 66X after Medicare has paid its eligible portion.

Medicare coinsurance claims

o If Medicare is involved in the payment of the claim, the explanation of benefits (EOB)/ remittance advice (RA) from Medicare **must** be included with the submission of the UB-04 paper claim form.

o When submitting a paper claim, do not put Medicare payment information in the **Other Insurance** field, or the claim will be denied.

o When the Medicare payment equals or exceeds the lowest of the Medicaid or Medicare allowable, HIPAA Claim Adjustment Reason Code (CARC) 23 and EOB code 0095 are applied and will appear on the RA. The claim is paid zero dollars because Medicare paid the maximum allowable.

If the claim contains room and board with ancillary services **and** the provider received **Part A and B** payment, the claim will be processed through the Medicare Algorithm for the **Part A** payment and the **Part B** payment will be applied as a Third-Party Liability (TPL) payment. If only a **Part B** payment has been made, indicate in Box 50, "Medicare Part B only". If the provider bills only ancillary services, those claims will be denied as content of service to the room and board claim.

If **Part A** coverage is exhausted before or during the patient's stay, use Condition Code 67 (Member elects not to use lifetime reserve days) or Occurrence Code A3 (Benefits exhausted) and put the date the benefits were exhausted on the claim. If Condition Code 67 is used, the Occurrence Code A3 and corresponding date must be present.

UB-04 Instructions

Billing Instructions

The following numbered form locators (FL) are to be completed when required or if applicable.

Note: **For all fields requiring a National Provider Identifier (NPI), the associated provider must be enrolled with KMAP and have a valid NPI on file for the claim to be considered for payment. Reference Section 2000 of the *General Benefits Fee-for-Service Provider Manual*.**

FL 1	**BILLING PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER (*Required*)**
	
	 Enter the name, address, and telephone number of the billing provider.
	
	      Line 1 – Billing Provider Name
	      Line 2 – Street Address
	          Note*: Post Office Box or Lock Box must not be used.*
	      Line 3 – City, State, ZIP Code
	          Note: *Enter the full nine-digit ZIP code.*
	      Line 4 – Telephone #

FL 2	**BILLING PROVIDER'S DESIGNATED PAY-TO-ADDRESS** This field is not used by Kansas Medicaid.
FL 3a	**PATIENT CONTROL NUMBER** *(Required)* Enter the member's account number. This number will appear on the Remittance Advice (RA).
FL 3b	**MEDICAL/HEALTH RECORD NUMBER** Enter the member's medical record number. This number will appear on the RA.

FL 4	**TYPE OF BILL (*Required*)**
	
	 Enter the three-digit number specific to the type of claim.
	
	 Note: **Only the codes in bold below are applicable to NFs.**
	
	 Medicaid allowed codes:
	 • 1st digit indicates facility.
	      ▪ **1** **Hospital (IP/OP)**
	      ▪ **2** **Skilled nursing**
	      ▪ **6** **Intermediate care**
	      ▪ 8 Outpatient – Critical Access
	 • 2nd digit indicates location within facility.
	      ▪ 1 Inpatient
	      ▪ 3 Outpatient
	      ▪ **5** **Level I**
	      ▪ **6** **Level II**
	      ▪ 8 Swing bed NF
	 • 3rd digit indicates the frequency of the claim billed.
	      ▪ 0 Nonpayment/zero claim
	      ▪ 1 Admit through discharge claim
	      ▪ 2 Interim - first claim
	      ▪ 3 Interim - continuing claim
	      ▪ 4 Interim - last claim (thru date is discharge date)

UB-04 Instructions

FL 5	**FEDERAL TAX NUMBER (*Required*)** Enter the federal tax number as in the Lower Line: NN-NNNNNNN.
FL 6	**STATEMENT COVERS PERIOD (FROM-THROUGH) (*Required*)** Enter the span of service dates included in this bill. 1. All services received on a single day, report the same date for the "From" and "Through" dates. 2. Enter both dates as MMDDYY. **Example:** 010122 3. The "From" date must be reported as the earliest date of service.
FL 7	**Reserved for Assignment by the National Uniform Billing Committee (NUBC)** This field is not used by Kansas Medicaid.
FL 8	**PATIENT NAME/IDENTIFIER (*Required*)** Enter the member's last name, first name, and middle initial exactly as it appears on the KMAP ID card. If patient is a newborn, enter "newborn", "baby boy", or "baby girl" in the first name field and enter the mother's last name.

FL 9	**PATIENT ADDRESS (*Required*)**
	
	Enter the full address of the member.
	    a – Street Address
	    b – City
	    c – State
	    d – ZIP Code
	    e – Plus 4

FL 10	**PATIENT BIRTH DATE (*Required*)** Enter member's date of birth in MMDDYYYY format. Example: 01012004 1. If newborn, enter baby's date of birth (not mother's). 2. If full date of birth is unknown, enter zeros for all eight digits.
FL 11	**PATIENT SEX (*Required*)** Enter "M" for male or "F" for female. If newborn, enter "M" or "F" to indicate the baby's sex.
FL 12	**ADMISSION/START OF CARE DATE (*Required*)** 1. Enter the date the patient was admitted as an inpatient to the facility. *Required on all inpatient claims regardless of whether it is an initial, interim, or final bill.* 2. Enter the date the episode of care began for home health and hospice services. 3. Enter date in MMDDYY format. **Example:** 010122
FL 13	**ADMISSION HOUR** ***Required on all inpatient claims except for Type of Bill 021x*** Enter treatment hour using the continental time system (6:00 p.m. equals 1800 hours).

UB-04 Instructions

FL 14	**TYPE OF ADMISSION OR VISIT**
	Required on all inpatient claims except for Type of Bill 021x
	
	Enter a one-digit code to indicate type of admission/visit.
	    1 – Emergency
	    2 – Urgent
	    3 – Elective
	    4 – Newborn
	    5 – Trauma
	    9 – Information Not Available
	
	Reference the *Official UB-04 Data Specifications Manual* for specific instructions on usage of the above values.

FL 15	**POINT OF ORIGIN FOR ADMISSION OR VISIT** *Required on all inpatient claims except for Type of Bill 014x.* Enter a one-digit code to indicate admission source. Reference the *Official UB-04 Data Specifications Manual* for valid values and specific instructions on usage.

FL 16	**DISCHARGE HOUR**
	Required on all FINAL inpatient claims except for Type of Bill 021x.
	
	The discharge hour is required on inpatient claims with a "Frequency Code" of:
	    1 – Admit through Discharge
	    4 – Interim/Last Claim
	    7 – Replacement of Prior Claim **(**excluding TOB 021x)

FL 17	**PATIENT DISCHARGE STATUS** *Required on all inpatient claims.* Enter a two-digit code to indicate the status of the member. Reference the *Official UB-04 Data Specifications Manual* for valid values and usage. *Note:* Hospitals will be eligible for full DRG reimbursement when a discharge occurs using discharge code 01, 03, 04, 05, 06, 07, 08, 20, 50, or 51. Distinct claim forms must be submitted for each discharge. In the case of transfers to same specialty providers (discharge code 02), the <u>transferring</u> hospital's reimbursement may be reduced, based upon a transfer prorated reimbursement determination, and the **receiving** hospital will be eligible to receive a full DRG reimbursement.
FL 18-28	**CONDITION CODES** Enter a two-digit code to indicate a condition(s) relating to inpatient or outpatient claims, special programs, or procedures (e.g. KAN Be Healthy, sterilization). Reference the *Official UB-04 Data Specifications Manual* for valid values. Reference the *KMAP Hospital Fee-For-Service Provider Manual* for any specific billing instructions that may apply.
FL 29	**ACCIDENT STATE** *Required, if applicable.* Enter the two-digit state abbreviation code where the accident occurred.

UB-04 Instructions

FL 30	**RESERVED FOR ASSIGNMENT BY THE NUBC** This field is not used by Kansas Medicaid.
FL 31-34	**OCCURRENCE CODES AND DATES** *Required when an occurrence code applies to the claim.* Enter occurrence code(s) and date(s). Enter dates in MMDDYY format. Example: 010122 Occurrence code values can only be submitted on lines 31a, 32a, 33a, 34a, 31b, 32b, 33b, 34b. Occurrence codes must be indicated if reporting information on type of accident, crime victim, other insurance denial or date of TPL termination, or aborted surgery, false labor or non-delivery claim where associated services are indicated. All Kansas Department for Children and Families (DCF) guidelines remain the same regarding attachments required for Termination of Parental Rights (TPR) proof and Social Security Administration (SSA)/Medicare Explanation of Medical Benefits (EOMBs). Reference the *Official UB-04 Data Specifications Manual* for valid values. Reference the *KMAP Hospital Fee-For-Service Provider Manual* for any specific billing instructions that may apply.
FL 35-36	**OCCURRENCE SPAN CODES AND DATES** *Required when an occurrence has happened over a span of time.* Enter occurrence span code(s) and from and through date(s). Enter dates in MMDDYY format. Example**:** 010122 Occurrence span code values can only be submitted on lines 35a, 36a, 35b, and 36b. Reference the *Official UB-04 Data Specifications Manual* for valid values.
FL 37	**RESERVED FOR ASSIGNMENT BY THE NUBC** This field is not used by Kansas Medicaid.
FL 38	**RESPONSIBLE PARTY NAME AND ADDRESS (CLAIM ADDRESSEE)** This field is not used by Kansas Medicaid.
FL 39-41	**VALUE CODES (Required, if applicable)** Enter the appropriate two-digit value code and applicable amount. Reference the *Official UB-04 Data Specifications Manual* for valid values. • Under CODE, enter D3 for nonpatient obligation. Under AMOUNT, enter the nonpatient obligation dollar amount. Examples of nonpatient obligation are Parental, Spousal, and Trust. • Under CODE, enter 80 for covered days. Under AMOUNT, enter the number of covered days. *Note:* Count the date of admission but not the date of discharge.
FL 42	**REVENUE CODES (*Required – inpatient only*)** Enter the three-digit revenue code identifying the type of accommodation and ancillary service(s). *Note:* Do not indicate revenue code(s) if the service is noncovered. *Note:* Revenue codes are not to be indicated for outpatient services.

UB-04 Instructions

FL 42	Reference the ***Official UB-04 Data Specifications Manual*** for a code list.
	Reference the ***KMAP Hospital Fee-For-Service Provider Manual*** for any specific billing instructions that may apply.
FL 43	**REVENUE DESCRIPTION/IDE NUMBER/MEDICAID DRUG REBATE/LINE LEVEL RENDERING PROVIDER NPI**
	If billing a service with a NDC, include all the required information in this field. The N4 qualifier must be present before the NDC number, followed by the unit/basis of measurement and number of units. **Example:** N412345678901UN1234.567
	The following qualifiers are accepted for the NDC unit/basis of measurement: • F2 – International Unit • GR – Gram • ME – Milligram • ML – Milliliter • UN – Unit
	Additional information is available on the NUBC website.
FL 44	**HCPCS / ACCOMODATION RATES/HIPPS RATE CODES** *(Required – outpatient only)*
	List the procedure code and modifier (if applicable) for each specific outpatient procedure. DO NOT INDICATE PROCEDURE(S) IF THE SERVICE IS NONCOVERED.
	Additional information is available on the NUBC website.
FL 45	**SERVICE/ASSESSMENT DATE (*Required – outpatient only*)**
	Enter the date services were provided in MM/DD/YY format.
FL 46	**SERVICE UNITS (*Required*)**
	Enter the number of days for each accommodation revenue code.
	Enter the appropriate units for each outpatient service billed.
FL 47	**TOTAL CHARGES** *(Required)*
	Enter total charges for each coded line item.
	List each outpatient procedure with a specific (itemized) charge. DO NOT INDICATE CHARGES FOR NONCOVERED SERVICES.
	Enter the total claim charge on the last line of this detail section with a revenue code of 001 in FL 42 and total charges in FL 47.
FL 48	**NON-COVERED CHARGES (*Situational*)**
	Enter noncovered charges.
FL 49	**RESERVED FOR ASSIGNMENT BY THE NUBC**
	This field is not used by Kansas Medicaid.

UB-04 Instructions

FL 50	**PAYER NAME** (*Required*)
	
	 Enter all third-party resources.
	      Line A – Use to indicate primary payer name.
	      Line B – Use to indicate secondary payer name.
	      Line C – Use to indicate tertiary payer name.
	
	 Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.

FL 51	**PAYER ID**
	
	 If other payers are involved in potentially paying the claim, enter the ID number used to identify the payer.
	      Line A – *Required*
	      Line B & C – *Situational*
	
	 Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.

FL 52	**RELEASE OF INFORMATION CERTIFICATION INDICATOR** *(Required)* Enter the release of information certification locator.

FL 53	**ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR** (*Required*)
	
	 This code indicates the provider has signed a form authorizing the third-party payer to remit payment directly to the provider.
	
	 Valid values:
	      N – No
	      W – Not applicable (Use when patient refuses to assign benefits.)
	      Y – Yes

FL 54	**PRIOR PAYMENTS – PAYER** (*Required if other insurance is involved*)
	
	 Report the other insurance payment amount. If there has not been a payment made by the other insurance, report 0.00.
	
	 When a Medicare Part B payment has been made on an Inpatient claim, indicate the amount paid as prior payment.
	
	 Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.
	      Line A – Use to indicate primary payment.
	      Line B – Use to indicate secondary payment.
	      Line C – Use to indicate tertiary payment.

FL 55	**ESTIMATED AMOUNT DUE – PAYER** (*Situational*)
	
	 Enter the estimated amount due (estimated responsibility less prior payments).
	
	 Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.
	      Line A – Primary
	      Line B – Secondary
	      Line C – Tertiary

UB-04 Instructions

FL 56	**NATIONAL PROVIDER IDENTIFIER (NPI) – BILLING PROVIDER (*Required*)** Enter the billing provider's NPI.
FL 57	**OTHER (BILLING) PROVIDER IDENTIFIER** Only required when an NPI is not used in FL 56 and an identification number other than the NPI is necessary to identify the provider or to report other provider identifiers as assigned by the health plan (as indicated in FL 50 Lines A-C) as required.

FL 58	**INSURED'S NAME (*Required*)**
	
	Enter the insured's name.
	    Line A – Primary
	    Line B – Secondary
	    Line C – Tertiary

FL 59	**PATIENT'S RELATIONSHIP TO INSURED**
	
	Enter the code to indicate the relationship of the patient to the identified insured.
	
	    Line A – *Required*
	    Line B & C – *Situational*
	
	    Code **Description**
	    01 Spouse
	    18 Self
	    19 Child
	    20 Employee
	    21 Unknown
	    39 Organ Donor
	    40 Cadaver Donor
	    53 Life Partner
	    G8 Other Relationship

FL 59a	**PRIMARY PAYER**
FL 59b	**SECONDARY PAYER**
FL 59c	**TERTIARY PAYER**

FL 60	**INSURED'S UNIQUE IDENTIFIER (*Required*)**
	
	Enter the 11-digit Medicaid member number from the patient's medical ID card on Line C. If newborn services, use the mother's Medicaid member number if the newborn's ID number is unknown.
	
	Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.
	    Line A – Primary insurance member ID
	    Line B – Secondary insurance member ID
	    Line C – Tertiary insurance member ID

FL 61	**INSURED'S GROUP NAME (*Required*)** The group or plan name through which the insurance is provided to the insured. Enter the insured's group name if it is available and FL 62 is not used. *Note:* If other insurance is involved in the payment of the claim, the EOB/RA from the other

UB-04 Instructions

FL 61	insurance **must** be included with the submission of the claim.
	    Line A – Primary
	    Line B – Secondary
	    Line C – Tertiary

FL 62	**INSURANCE GROUP NUMBER (*Required*)**
	
	Enter the insurance group number when the insured's ID card shows a group number.
	Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.
	    Line A – Primary
	    Line B – Secondary
	    Line C – Tertiary

FL 63	**AUTHORIZATION CODE/REFERRAL NUMBER (*Not required*)** Identifier designating the services on the bill have been authorized or a referral is involved by the payer or utilization management organization (UMO).
FL 63a	**AUTHORIZATION CODE** *Not required*
FL 63b	**REFERRAL NUMBER** *Not required*
FL 63c	**SECONDARY PAYER AUTHORIZATION CODE** *Not required*

FL 64	**DOCUMENT CONTROL NUMBER (DCN) (*Required*)**
	
	Enter the document control number assigned to the original bill by the health plan or the health plan's fiscal agent.
	
	Required when the TOB frequency code (FL 04) indicates this claim is a replacement or void to a previously adjudicated claim.
	
	Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.
	    Line A – Primary
	    Line B – Secondary
	    Line C – Tertiary

FL 65	**INSURED'S EMPLOYER NAME (*Situational*)**
	
	Enter the employer's name of the insured.
	
	Note: If other insurance is involved in the payment of the claim, the EOB/RA from the other insurance **must** be included with the submission of the claim.
	    Line A – Primary
	    Line B – Secondary
	    Line C – Tertiary

FL 66	**DIAGNOSIS AND PROCEDURE CODE QUALIFIER (*Required*)** Enter qualifier code 0 for ICD-10 diagnoses and ICD-10-PCS, as appropriate.

UB-04 Instructions

FL 67	**PRINCIPAL DIAGNOSIS AND PRESENT ON ADMISSION INDICATOR (*Required*)** Enter the principal diagnosis code and present on admission indicator. Follow the ***ICD-10-CM Official Guidelines*** for coding and reporting. POA requirements for ECI, refer to FL 72. *Note:* The POA indicators are not required for swing bed services.
FL 67 A-Q	**OTHER DIAGNOSIS AND PRESENT ON ADMISSION INDICATOR (*Required*)** Enter the other diagnoses code(s) when other conditions coexist or develop during the patient's treatment and enter the present on admission (POA) indicator(s) when other diagnoses are included. Follow the ***ICD-10-CM Official Guidelines*** and the official ***UB-04 Data Specifications Manual*** for coding and reporting. *Note:* The POA code must be typed on the paper claim form. If handwritten, the code may not be recognized.
FL 68	**RESERVED FOR ASSIGNMENT BY THE NUBC** This field is not used by Kansas Medicaid.
FL 69	**ADMITTING DIAGNOSIS CODE** ***Required on 012X, 022X, and Inpatient claims, except 028X, 065X, and 066X.*** Admitting diagnosis is required when the claim involves an inpatient admission.

FL 70	**PATIENT'S REASON FOR VISIT (*Situational*)**
	
	Enter the ICD diagnosis code appropriate to the ICD revision indicated in FL 66 which describes the patient's stated reason for the visit at the time of outpatient registration.
	
	    1. Required on Type of Bill 013x, 078x and 085x when:
	        a. FL 14 (Priority (Type) of Admission or Visit) codes 1, 2 or 5 are reported and
	        b. Revenue Codes 045x, 0516, 0526, or 0762 are reported.
	
	    2. Reporting Patient's Reason for Visit is restricted to the three bill types above.
	        a. If not required, it may be reported on other 013x, 078x, and 085x bill types that fail to meet the criteria in a) or b) above at the sender's discretion when this information substantiates the medical necessity.
	
	Follow the ***ICD-10-CM Official Guidelines*** and the official ***UB-04 Data Specifications Manual*** for coding and reporting.
	
	Note: No POA is required for outpatient claim forms.

FL 71	**PROSPECTIVE PAYMENT SYSTEM (PPS) CODE** Enter the prospective payment system code that identifies the DRG based on the grouper software.
FL 72 A-C	**EXTERNAL CAUSE OF INJURY (ECI) CODE AND PRESENT ON ADMISSION INDICATOR (*Situational*)** Enter the external cause of injury code when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during medical treatment.

UB-04 Instructions

FL 72 **A-C**	Do not report the decimal between the third and fourth characters as it is considered implied. *Note:* The POA code must be typed on the paper claim form. If handwritten, the code may not be recognized. Follow the ***ICD-10-CM Official Guidelines*** and the official ***UB-04 Data Specifications Manual*** for coding and reporting.
FL 73	**RESERVED FOR ASSIGNMENT BY THE NUBC** This field is not used by Kansas Medicaid.
FL 74	**PRINCIPAL PROCEDURE CODE AND DATE** *Required for inpatient hospital claims, if applicable.* Enter the ICD procedure code for the primary procedure and date of service for inpatient claims. Do not report the decimal between the second and third characters as it is considered implied.
FL 74 **A-E**	**OTHER PROCEDURE CODES AND DATES** *Required for hospital inpatient claims, if applicable.* Enter the other procedure(s) performed, using ICD procedure code(s) and date of service. Do not report the decimal between the second and third characters as it is considered implied.
FL 75	**RESERVED FOR ASSSIGNMENT BY THE NUBC** This field is not used by Kansas Medicaid.
FL 76	**ATTENDING PROVIDER NAME AND IDENTIFIERS** *Required.* **Do not enter a group NPI provider number.** **NPI –** Enter the provider's National Provider Identifier. **QUAL:** • **G2 -** Enter qualifier G2 when submitting with the KMAP provider ID. The KMAP provider ID should only be submitted in the absence of the required NPI number. • **PXC -** Enter qualifier PXC when submitting with the taxonomy code. *Note:* Enter the KMAP provider ID or taxonomy code in the space to the right of QUAL. **LAST –** Enter the provider's last name. **FIRST –** Enter the provider's first name.
FL 77	**OPERATING PHYSICIAN NAME AND IDENTIFIERS** *(Required, if applicable)* **NPI –** Enter the provider's National Provider Identifier. **QUAL:** • **G2 -** Enter qualifier G2 when submitting with the KMAP provider ID. The KMAP provider ID should only be submitted in the absence of the required NPI number. • **PXC -** Enter qualifier PXC when submitting with the taxonomy code. *Note*: Enter the KMAP provider ID or taxonomy code in the space to the right of QUAL. **LAST –** Enter the provider's last name. **FIRST –** Enter the provider's first name.

UB-04 Instructions

FL 78-79	**OTHER PROVIDER (INDIVIDUAL) NAMES AND IDENTIFIERS** *(Required, if applicable)*
	
	NPI – Enter the provider's National Provider Identifier.
	
	QUAL:
	    • **G2 -** Enter qualifier G2 (Commercial Number) when submitting with the KMAP provider ID. The KMAP provider ID should only be submitted in the absence of the required NPI number.
	    • **PXC -** Enter qualifier PXC when submitting with the taxonomy code.
	Note: Enter the KMAP provider ID or taxonomy code in the space to the right of QUAL.
	
	Note: If the claim is for sterilization, the surgeon performing the sterilization procedure must be identified by their NPI number in FL 78.

FL 80	**REMARKS FIELD** Specify additional information as necessary. When billing medically necessary incoming transfers, the following should be entered on claims for incoming transfers from other hospitals: "Direct transfer from (hospital, city)".

FL 81	**CODE-CODE FIELD**
	
	Enter additional codes related to field locator overflow or to report externally maintained codes approved by the NUBC.
	
	    LEFT COLUMN – Qualifier
	    MIDDLE COLUMN – Code
	    RIGHT COLUMN – Number or value
	
	Refer to the ***Official UB-04 Data Specifications Manual*** for usage and examples.