3.0 UB-04 Claim Form

This section explains the procedures for obtaining reimbursement for services submitted to Medicaid on the UB-04 billing form, and must be used in conjunction with the MS Medicaid Administrative Code. You may refer to the administrative code and fee schedules for issues concerning policy and the specific procedures for which Medicaid reimburses. If you have questions, please contact the fiscal agent's Provider Services Call Center toll-free at 1-800-884-3222.

Provider Types

The following provider types should bill using the UB-04 claim form

- Dialysis Centers
- Home Health Agencies
- Hospice Providers
- Hospitals
- Intermediate Care Facility for Individuals with Intellectual Disabilities (**ICF/IID)**
- Nursing Facilities
- Psychiatric Residential Treatment Facilities (**PRTF**)
- Swing-Bed

Web Portal Reminder

Providers are encouraged to use the Mississippi Envision Web Portal for easy access to up-to-date information. The web portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The web portal is available 24 hours a day, 7 days a week, 365 days a year via the Internet at http://msmedicaid.acs-inc.com.

Paper Claim Reminders

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Complete an original UB-04 claim form.
- No photocopied claims will be accepted.
- Use blue or black ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc., print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.

Multi-Page Paper Claims

When submitting UB-04 claims with multiple pages, please follow these guidelines:

- Multi-page claims are **limited to 2 pages** with a maximum of **44 claim lines**.
- Do not total the first form.
- Staple or clip the 2 pages together, but do not staple more than once.
- Indicate **Page X of 2** in **line 23** of **Field 42**.
- Revenue **code 0001** (total charges) must be on the **second page**.
- If reporting TPL payment, indicate in **field 54** on the **first page**.
- Only one copy of an attachment (e.g. EOB, EOMB, and Consent Form) is required per claim.

Paper Claims with Attachments

When submitting attachments with the UB-04 claim form, please follow these guidelines:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with more than one third- party payor source, include all EOBs that relate to the claim.
- For third party payments less than 20% of charges, indicate on the face of the claim, LESS THAN 20%, PROOF ATTACHED.
- For Medicare denials, indicate on the claim, MEDICARE DENIAL, SEE ATTACHED.
- For other insurance denials, indicate on the claim, TPL DENIAL, SEE ATTACHED.

Electronic UB-04 Claims

Electronic UB-04claims may be submitted to Mississippi Medicaid by these methods:

- Using the Web Portal Claims Entry feature
- Using WINASAP (free software available from the fiscal agent)
- Using other proprietary software purchased by the provider
- Using a clearinghouse to forward claims to Mississippi Medicaid.

Electronic UB-04 claims must be submitted in a format that is HIPAA compliant with the ANSI X 12 UB-04 claim standards.

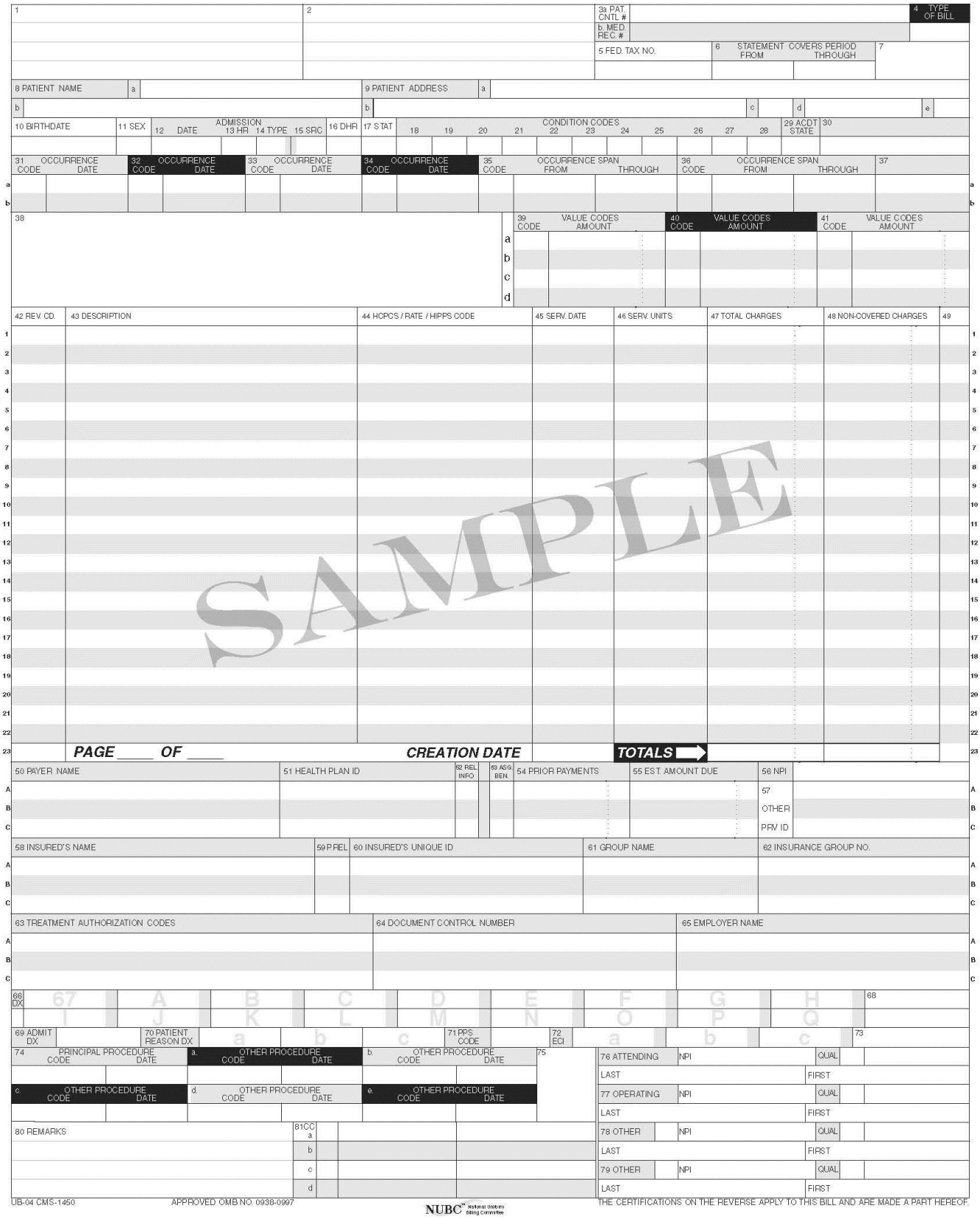
Billing Tip 

Be sure to include prior authorization number, timely filing TCN, proper procedure codes, modifiers, units, etc., to prevent your claim from denying inappropriately.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 ADMISSION DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
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
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
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 I J K L M N O P Q
68
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
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC
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.

UB-04 Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for UB-04 Form
1	**Required**	**Billing Provider Name, Address and Telephone Number:** Enter the name, address and telephone number of the billing provider exactly as it appears in the upper left corner of the remittance advice. Enter the provider's mailing address, city, state, ZIP code and telephone. Line 1 – Provider Name Line 2 – Provider Street Address Line 3 – Provider City, State, Zip Line 4 – Provider Telephone, FAX, Country
2	Not Required	Pay-to Name and Address (Unlabeled on Form)
3a	**Optional**	**Patient Control Number:** You may enter the patient's unique account number assigned by the provider account number. If the patient's account number is listed on the claim, it will be appear on the remittance advice.
3b	**Required if Applicable**	**Medical/Health Record Number**: Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility.
4	**Required**	**Type of Bill:** Enter the appropriate type of bill code. This code indicates the specific type of bill being submitted and is critical to ensure accurate payment. See **Figure 3-2** at the end of this section.  **Types of bill xx7 or xx8 are reserved for electronic adjustment/void only.**
5	Not Required	Federal Tax Number: Not required.
6	**Required**	**Statement Covers Period:** Enter the beginning service date in the "From" area and the last service date in the "Through" area of this field. Use MMDDYY format for each date. For services received on a single day, use the same "From" and "Through" dates. For **outpatient services**, enter the first visit in the "From" block and the date of the last visit in the "Through" block. For **inpatient services**, the "From" date must always equal the date of admission with the following three exceptions: • The second half of a split bill • The patient's Medicaid eligibility begins after the admission date • The baby remains hospitalized after the mother is discharged. For **Psychiatric Residential Treatment Facility (PRTF)** claims, the "From" date must always equal the date of admission with the following exceptions: • The second half of a split bill, or • The patient's Medicaid eligibility begins after the admission date.
7	Not Required	Reserved for Assignment by the NUBC
8a	Not Required	Patient Name/Identifier
8b	**Required**	**Patient Name:** Enter the beneficiary's name as it appears on the Medicaid ID card in the last name, first name, and middle initial format.

Field	Requirement	Field Name and Instructions for UB-04 Form
9a-e	Not Required	Patient Address
10	**Required**	**Patient Birth Date:** Enter the beneficiary's birth date in MM/DD/YYYY format.
11	**Required**	**Patient Sex:** Enter the sex of the patient. M – Male, F – Female, U - Unknown
12	**Required if Applicable**	**Admission Date:** Enter the month, day, and year of the admission of the beneficiary in the MM/DD/YY format. • This field is not required for Dialysis Center claims. • For Nursing Facility claims, use the original admission date that the patient entered the facility.
13	**Required if Applicable**	**Admission Hour:** Enter the time of admission in military time (24 hour clock). See **Figure 3-3** at the end of this section.
14	**Required if Applicable**	**Type of Admission/Visit:** Enter the appropriate admission code. See **Figure 3-4** for a list of admission types.
15	**Required if Applicable**	**Source of Referral for Admission or Visit**: Enter the source of referral for this admission or visit. See **Figure 3-5** at the end of this section for a list of admission source codes.
16	Not Required	Discharge Hour
17	**Required**	**Patient Discharge Status:** Indicate the beneficiary's disposition or discharge status at the end of service for the period covered on this bill, as reported in Field 6, Statement Covers Period. See **Figure 3-6** at the end of this section for a list of status codes.
18-28	**Required if Applicable**	**Condition Codes**: If applicable, indicate conditions or events relating to this claim. Enter the appropriate condition code taken from the Uniform Billing Manual.
29	Not Required	Accident State
30	Not Required	Reserved for Assignment by the NUBC
31-34	**Required if Applicable**	**Occurrence Codes and Dates:** Enter the appropriate occurrence code and date MM/DD/YYYY format. See the Uniform Billing Manual.  **For <u>inpatient claims</u>, use occurrence code C3 along with the date of discharge to bill a one-day stay for a claim with the same "From" and "Through" service date.** **For <u>inpatient claims</u>, to show that benefits are exhausted, use occurrence code C3 with the date that benefits ended along with code 42 to show the actual date of discharge from the facility.**
35-36	Not Required	Occurrence Span Codes and Dates
37	Not Required	Reserved for Assignment by the NUBC
38	Not Required	Responsible Party Name and Address

Field	Requirement	Field Name and Instructions for UB-04 Form
39-41	Required if Applicable	**Value Codes and Amounts:** Enter the appropriate value code and amount. See the Uniform Billing Manual for Value Code structure. The following value codes should be entered on the form in these fields:  To show **covered days**, use **value code 80.** For non-amount related value codes, include decimals. For example, to report 5 covered days on a claim, enter Value Code 80 and enter it as 5 in the amount field and 00 in the decimal place.
42	Required	**Revenue Code:** Enter the revenue code that identifies a specific service or item. The specific revenue codes can be taken from the revenue code section of the Uniform Billing Manual. See **Figure 3-7** at the end of this section for a partial list of revenue codes. **Figure 3-7** contains the only revenue codes billable to Mississippi Medicaid for the specific provider types listed. For an all-inclusive list of revenue codes see the Uniform Billing Manual.
43	Required	**Revenue Code Description:** Enter the standard abbreviation of the narrative description for revenue code. Revenue descriptions are listed in the revenue code section of the Uniform Billing Manual. • **For Dialysis Providers: Enter the 11-digit NDC code number for physician-administered drugs in the Revenue Code description field.**
44	Required if Applicable	**HCPCS/Accommodation Rates/HIPPS Rate Codes:** For **inpatient services**, **Nursing Facility/ICFMR services**, **Swing-Bed services** or **PRTF services** enter the **accommodations rate.** For **outpatient services** or **Dialysis Center services**, enter the appropriate **CPT or HCPCS procedure code** for services including but not limited to lab and radiology procedures, diagnostic tests, and injectable drugs.
45	Required if Applicable	**Service Date:** Enter the month, day, and year in MM/DD/YY format for **Dialysis Center claims** and **hospital outpatient services only**.
46	Required	**Service Units**: Enter the total number of covered accommodation days, ancillary units of service, or visits being billed per procedure or revenue code.
47	Required	**Total Charges:** Enter the total charges pertaining to the related revenue codes for the billing period as entered in Field 6 Statement Covers Period. Enter the grand total charges at the bottom of this field with revenue code 0001 in form locator 42.
48	Required if Applicable	**Non-covered Charges:** Enter the charge for any non-covered services such as take-home drugs or services by private duty nurses.
49	Not Required	Reserved for Assignment by the NUBC

Field	Requirement	Field Name and Instructions for UB-04 Form
50A-C	**Required**	**Payer Name:** As applicable, enter the name of the beneficiary's primary, secondary, and tertiary insurance on Lines A, B and C, respectively. **On claims with no TPL, Medicaid information is entered on Line A.**
51A-C	Not Required	Health Plan ID
52A-C	Not Required	Release of Information
53A-C	Not Required	Assignment of Benefits
54A-C	**Required if Applicable**	**Prior Payments:** Enter payment received from any other insurance carriers.  **Do not include contractual adjustments when no payment from the third party source is made. Do not enter prior payments from Medicare or Medicaid as it may cause your claim to pay at zero dollars or a reduced rate.**
55A-C	Not Required	Estimated Amount Due
56	**Required**	**National Provider Identifier (NPI) –** Enter the National Provider Identifier for the billing provider.
57A-C	**Optional**	**Other Provider Identifier:** Enter the eight-digit MS Medicaid ID number.
58A-C	**Required**	**Insured's Name:** As applicable, enter the insured's name for the primary, secondary and tertiary insurance on Lines A, B and C, according to proper billing order. On the line that shows payor, "Medicaid," enter the beneficiary's name exactly as shown on the Medicaid card.
59A-C	**Required**	**Patient's Relationship to Insured:** Enter the code indicating the relationship of the patient to the identified insured. The following codes are acceptable to report the required information: Code – Title 01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 – Organ Donor 40 – Cadaver Donor 53 – Life Partner G8 – Other Relationship

Field	Requirement	Field Name and Instructions for UB-04 Form
60A-C	**Required**	**Insured's Unique Identifier:** As applicable, enter the insured's unique identifier for the primary, secondary and tertiary insurance on Lines A, B and C, according to proper billing order. On the line that shows payor, "Medicaid," enter the 9-digit Medicaid beneficiary ID Number as shown on the beneficiary's Medicaid card. Do not include spaces or hyphens.  If the beneficiary is exempt from co-payment, enter the applicable exception code immediately following the Medicaid ID number.
61A-C	**Required if Applicable**	**Insured's Group Name:** As applicable, enter the group name of the beneficiary's primary, secondary and tertiary insurance on Lines A, B and C, according to proper billing order. Do not enter a group name on the line that shows payor, "Medicaid."
62A-C	**Required if Applicable**	**Insured's Group Number:** As applicable, enter the group number of the beneficiary's primary, secondary and tertiary insurance on Lines A, B and C, according to proper billing order. Do not enter a group number on the line that shows payor, "Medicaid."
63A-C	**Required if Applicable**	**Treatment Authorization Code:** Enter the TAN authorization number in this field. Only one authorization number may be entered per claim.
64	**Required if Applicable**	**Document Control Number:** Enter the transaction control number (TCN) of the original claim for proof of timely filing on a resubmission of a claim twelve months past the original date of service.
65A-C	**Required if Applicable**	**Employer Name:** Enter the name of the employer that could provide a source of third party insurance payment.
66	Not Required	Diagnosis Version Qualifier
67	**Required**	**Principal Diagnosis Code:** Enter the ICD-9-CM code for the principal diagnosis codes that relate to the billing period.
67A-Q	**Required if Applicable**	**Other Diagnosis Codes:** Enter an ICD-9-CM diagnosis code for each condition that coexists at the time of admission, that develops subsequently, or that affects the treatment received and/or the length of stay.
68	Not Required	Reserved for Assignment by the NUBC
69	**Required**	**Admitting Diagnosis Code**: Enter the ICD-9-CM diagnosis code describing the beneficiary's reason for admission as stated by the physician.
70a-c	Not Required	Patient's Reason for Visit
71	Not Required	Prospective Payment System (PPS) Code
72a-c	Not Required	External Cause of Injury (ECI) Code
73	Not Required	Reserved for Assignment by the NUBC
74	**Required if Applicable**	**Principal Procedure Code and Date:** Enter the appropriate ICD-9-CM procedure code. Record the date in the MM/DD/YY format.  **For family planning outpatient services, indicate the appropriate ICD-9-CM code in fields 74 and 74a - e.**

Field	Requirement	Field Name and Instructions for UB-04 Form
74a-e	**Required if Applicable**	**Other Procedure Codes and Dates:** Enter procedure codes to identify all significant procedures (other than the principal) and the dates on which each procedure was performed (MMDDYY format).
75	Not Required	Reserved for Assignment by the NUBC
76	**Required if Applicable**	**Attending Provider Name and Identifiers:** Enter the Attending, Ordering, or Referring Provider NPI if the admit source is 2 – Clinics; 4 – Transfer from Different Hospital; 6 – TRN from Other HCF/Born Outside; E – Transfer from ASC or F – Transfer from Hospice. Enter the Attending, Referring, or Ordering Provider's last name and First Name. Qualifier Code- Not Required.
77	Not Required	Operating Physician Name and Identifiers
78	**Required if Applicable**	**Other Provider (Individual) Names and Identifiers:** Enter the NPI for the other provider. Qualifier Codes are not required.
79	Not Required	Other Provider (Individual) Names and Identifiers
80	**Required if Applicable**	**Remarks Field:** Use this area for notations, providing additional information necessary to adjudicate the claim.
81A-D	Not Required	Code-Code Field: Use this field to report additional value codes and taxonomy codes.

Figure 3-1. Checklist of Required UB-04 Fields.

UB-04 Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
1 Provider Name	✓			
2 Pay-to Name				✓
3a Patient Control No.			✓	
3b Medical Record Number		✓		
4 Type of Bill	✓			
5 Fed. Tax. No.				✓
6 Statement Covers Period	✓			
7 Reserved for Assignment				✓
8a Patient Name - ID				✓
8b Patient Name	✓			
9a Patient Address-Street				✓
9b Patient Address-City				✓
9c Patient Address-State				✓
9d Patient Address - Zip				✓
9e Patient Add.-Country Code				✓
10 Patient Birth Date	✓			
11 Patient Sex	✓			
12 Admission Date	✓			
13 Admission Hour		✓		
14 Admission Type		✓		
15 Source of Referral		✓		
16 Discharge Hour				✓
17 Patient Discharge Status	✓			
18 – 28 Condition Codes		✓		
29 Accident State				✓
30 Reserved for Assignment				✓
31 – 34 Occurrence Codes and Dates		✓		
35 – 36 Occurrence Span and Dates				✓
37 Reserved for Assignment				✓
38 Responsible Party				✓
39-41 Value Codes/Amounts		✓		
42 Revenue Code	✓			
43 Rev. Code Description	✓			
44 HCPCS/Rates/HIPPS Codes		✓		
45 Service Date		✓		
46 Units of Service	✓			
47 Total Charges	✓			
48 Non-Covered Charges		✓		

UB-04 Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
49 Reserved for Assignment				✓
50A-C Payer Name	✓			
51A-C Health Plan ID				✓
52A-C Release of Information				✓
53A-C Assignment of Benefits				✓
54A-C Prior Payments		✓		
55A-C Est. Amount Due				✓
56 NPI	✓			
57A-C Other Provider ID			✓	
58 A-C Insured's Name	✓			
59 A-C Patient's Relationship	✓			
60A-C Insured's Unique ID	✓			
61A-C Group Name		✓		
62A-C Insurance Group No.		✓		
63 Treatment Authorization Code		✓		
64 Document Control No.		✓		
65A-C Employer Name		✓		
66 Diagnosis Version Qual.				✓
67 Principal Diagnosis Code	✓			
67 a-q Other Diag. Codes		✓		
68 Reserved for Assignment				✓
69 Admitting Diagnosis Code	✓			
70 -73 Fields				✓
74 Principal Procedure Code and Date		✓		
74 a - e Other Procedure Codes and Dates		✓		
75 Reserved for Assignment				✓
76 Attending, Ordering, or Referring Physician Information		✓		
77 Operating Physician Info				✓
78 Other Provider Name/ID		✓		
79 Other Provider Name/ID				✓
80 Remarks		✓		
81 a - d Code-Code Field				✓

Figure 3-2. Examples of Type of Bill (Field 4)

Bill Type	Definition
0111	Hospital Inpatient—complete stay, admission through discharge
0112	Hospital Inpatient—patient is admitted and is still a patient, first half of a split bill
0113	Hospital Inpatient—patient is a patient for the full month, interim bill
0114	Hospital Inpatient—patient is discharged in a different month from admission, second half of a split bill
0131	Outpatient
0181	Swing bed – used when the claim is for a complete stay, admission through discharge
0182	Swing bed – used when the patient is admitted and is still a patient through the date noted in Form Locator 6. This claim is the first part of a split bill.
0183	Swing bed – used when the beneficiary is a patient for the full month of billing, having been admitted in a previous month. This claim is an interim bill.
0184	Swing bed - used when a patient is discharged in a different month from admission. This claim is the final bill.
0721	Freestanding renal dialysis centers or hospital based dialysis units
0811	Hospice (non-hospital based)
0821	Hospice (hospital-based)
0891	PRTF and Nursing Facility-complete stay, admission through discharge.
0892	PRTF and Nursing Facility – patient is admitted and is still a resident, first half of a split bill
0893	PRTF and Nursing Facility – patient is a resident for the full month, interim bill
0894	PRTF and Nursing Facility – patient is discharged in a different month from admission, second half of a split bill

Figure 3-3. Admission Hour Code Structure (Field 13)

AM TIMES		PM TIMES	
Code	Time	Code	Time
00	12:00 Midnight – 12:59am	12	12:00 Noon – 12:59pm
01	01:00 – 01:59	13	01:00 – 01:59
02	02:00 – 02:59	14	02:00 – 02:59
03	03:00 – 03:59	15	03:00 – 03:59
04	04:00 – 04:59	16	04:00 – 04:59
05	05:00 – 05:59	17	05:00 – 05:59
06	06:00 – 06:59	18	06:00 – 06:59
07	07:00 – 07:59	19	07:00 – 07:59
08	08:00 – 08:59	20	08:00 – 08:59
09	09:00 – 09:59	21	09:00 – 09:59
10	10:00 – 10:59	22	10:00 – 10:59
11	11:00 – 11:59	23	11:00 – 11:59

Figure 3-4. Admission Types (Field 14)

Definition
Emergency: The patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling conditions.
Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder.
Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
Newborn: Any newborn infant born within a hospital setting.
Trauma Center: The patient visits a trauma center/hospital (as licensed or designated by the state or local government entity authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
Use this code only if admission type is "not available/NA": The provider is unable to clarify the type of admission; rarely used.

Figure 3-5. Admission Source (Field 15)

Code	Newborn Admission Sources/Definition
1-3	Discontinued
4	Born inside hospital
5	Born outside hospital
Code	**Admission Sources/Definition**
1	Non-healthcare Facility Point of Origin
*2	Clinic Referral
3	Discontinued
*4	Transfer from a Hospital (different facility)
5	Transfer from a Skilled Nursing Facility
*6	Transfer from another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information not available
A	Reserved for Assignment by NUBC
B	Transfer from another home health agency
C	Readmission to same home health agency
D	Transfer from one distinct unit of hospital to another distinct unit of hospital
*E	Transfer from Ambulatory Surgical Center
*F	Transfer from Hospice

Note: Admission Source Codes with * require NPI in Field 76

Figure 3-6. Patient Status (Field 17)

Code	Definition
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skill care
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
09	Admitted as an inpatient to this hospital
20	Expired
30	Still Patient
40	Expired at home (Medicare hospice claims only)
41	Expired in a medical facility (e.g., hospital, SNF, ICF, or freestanding hospice) (Medicare hospice claims only)
42	Expired, place unknown
43	Discharged/transferred to federal healthcare facility
50	Discharged to Hospice-Home
51	Discharged to Hospice-Medical Facility (certified) providing hospice level of care
61	Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed
62	Discharged/transferred to inpatient rehabilitation facility, including rehabilitation-distinct part units of a hospital
63	Discharged/transferred to a Medicare-certified long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid, but not under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharges/transfers to a Critical Access hospital
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list

Figure 3-7. Revenue Codes (Field 42)

Code	Definition
Hospice	
0651	Routine home care
0652	Continuous home care
0655	Inpatient respite care
0656	General inpatient care (non-respite)
0659	Other hospice (nursing facility hospice)
Psychiatric Residential Treatment Facilities	
0101	All inclusive room and board
0183	Therapeutic leave
0185	Hospital leave
Nursing Facilities and ICF/IID	
0101	All inclusive room and board
0181	Hospital leave* **(End Date: 6/30/17)**
0183	Therapeutic leave
0185	Hospital Leave* **(Effective: 7/1/17)**
0194	Ventilator Dependent Care (VDC) – services became effective 1/1/2015. This code is applicable to residents of Nursing Facilities, but not Intermediate Care Facilities / Individuals with Intellectual Disabilities (ICF/IID).
Dialysis Centers	
0250	Pharmacy General Classification
0636	Drugs Requiring Detailed Coding
0821	Outpatient or Home Dialysis – Hemodialysis/Composite or Other Rate
0831	Outpatient or Home Dialysis – Peritoneal/Composite or Other Rate
0841	Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient or Home CAPD/Composite or Other Rate
0851	Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home CCPD/Composite or Other Rate
Home Health	
0270	Medical/Surgical Supplies and Devices – General
0421	Physical Therapy Visit
0441	Speech Therapy Visit
0551	Skilled Nurse Visit
0571	Home Health Aide Visit

****Note**: Effective July 1, 2017 revenue code 0185 – "leave of absence-reserved-nursing home (for hospitalization) is required for all hospital leave claims. This change is being made to meet compliance of the National Uniform Billing Committee.**