

Nursing Facility UB-04 Paper Billing Guide



Oregon Medicaid Nursing Facilities
January 2010

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INTRODUCTION

The UB-04 Nursing Facility Billing Guide is designed to assist Nursing Facility providers who bill the Department of Human Services (DHS) for Medicaid services, to complete the UB-04 paper claim form correctly the first time. This guide will give you step-by-step instructions so that DHS can pay you more quickly. Use this billing guide along with the Oregon Administrative Rules Chapter 411 Division 070 (nursing facility payment rules), which contain information on policy and covered services specific to nursing facilities.

This billing guide outlines the requirements for completion of the UB-04 prior to sending your claim to DHS for payment processing, as well as helpful hints on how to avoid common billing errors.

The most recent version of the Nursing Facility Billing Guide is available on the DHS website at <http://www.oregon.gov/DHS/spd/provtools/index.shtml>.

TERMS TO KNOW

- NUBC – National Uniform Billing Committee – the committee that determines the format of the UB-04.
- X12 Committee – Committee that determines the electronic claims formats.
- Electronic Data Interchange (EDI) – The electronic exchange of business documents from application to application in a federally mandated format (837 electronic format).
- Post Hospital Extended Care Benefit (PHEC) – This is an Oregon Health Plan benefit that consists of a stay of up to twenty days in a nursing facility to allow for discharge from a hospital to a nursing facility. See OAR 411-070-0033 for more information.
- Client – Means an individual for whom payment is made under the Oregon Medicaid Program.
- Resident (also referred to as a patient on the UB-04 claim form) – Means a person who has been admitted to, but not discharged from, a nursing facility.

CLAIMS PROCESSING

The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS). This system is a combination of people and computers working together to process claims.

Paper claims submitted by mail go first to the DHS Office of Document Management (ODM) Imaging Unit.

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given a Image Locator Number (ILN).
- The scanned documents are then identified and sorted by form type and indexed by identifiers such as resident name, prime identification number, the date of service, and provider number.
- The data and images are stored and translated to an XML formatted file by an Electronic Document Management System (EDMS).
- The XML file is then sent to the MMIS through an interface for claims processing.
- The MMIS assigns each claim an Internal Control Number (ICN) prior to processing the claims information.

Once the claim is processed through the MMIS, DHS staff can immediately access submitted claim information by checking certain MMIS screens.

The system performs established edits for presence and validity of data on all claims regardless of format used, e.g. paper, web portal or electronic. Once a week, the system audits all claims to ensure that they conform to program policy. Every weekend, a payment cycle runs, and the system produces checks for claims that successfully pass all edits and audits. The fewer questions the computer asks, the more quickly it can process the claim.

DHS staff members will review the claim only if MMIS cannot make a payment decision based on the information submitted and/or if DHS has intentionally set an edit for manual review. The system directs the claim to DHS staff for specific financial, medical or administrative manual review. There are two statuses for this type of claim review: one is known as a suspense (suspended) claim and the other is a financial hold.

DHS does not return claims to providers, including those that are denied. Instead, DHS creates a listing of all claims paid, suspended and/or denied. This information is available to the provider and is called a Remittance Advice (RA). The RA is available for receipt via

mail in paper form or electronically via a DHS electronic mailbox. For more information about how to receive an electronic RA, contact DHS EDI Support (see Appendix G).

CLAIM FORMATS

Paper Claim Formats

Paper claims submitted to DHS, must be submitted on the UB-04 claim form.

Nursing facility claims submitted on the Turn-Around Documents (TADs) or Extended Care Invoices (DHS 1039) will no longer be accepted.

DHS does not supply the UB-04 claim form. This form is available through local business forms suppliers, or by calling the Standard Register Company, Forms Division at 1-800-755-6405.

DHS will continue to accept the Individual Adjustment Request form (DMAP 1036) to adjust any PAID claim that has been processed. Always use the most recent ICN on the 1036 form.

DHS processes hardcopy claims using Optical Character Recognition (OCR) scanning. Make sure your claim forms meet OCR specifications. If your forms are not to scale, or if the fields on your form are not correctly aligned, DHS will manually enter your claim data, which may delay processing of the claim.

When purchasing your claim forms use the commercially available “**red form**” versions of the UB-04. DHS no longer accepts the black and white forms or copies. When claim forms are submitted on the “red form,” the red ink drops out and the OCR technology scans the claim data (black ink) directly into the claims processing system, which increases the accuracy and efficiency of claims processing. OCR cannot be used on black and white claim forms.

UB-04 DELIVERY METHODS

Mail the paper UB-04 paper claim forms to the following address:

Division of Medical Assistance Programs
PO Box 14956
Salem, OR 97309

FedEx or Drop Off:

If you wish to send the UB-04s by next day FedEx, or if you want to drop off the UB-04s at DHS, please send use the following address:

ODM
2850 Broadway Rd NE
Salem, OR 97303

Delivery via Fax (503) 378-4938:

If you wish to fax UB-04s to DHS, please use the fax number above. Please note: If you fax the claims forms, they will not be on the red forms. **This will cause a delay in processing your claims.**

Electronic claim formats

DHS Electronic Data Interchange (EDI) 837 Institutional claim format - Contact DHS EDI Support for more information on electronic billing at 888-690-9888, or through e-mail at: DHS.EDISupport@state.or.us, or at the EDI

Website: <http://www.oregon.gov/DHS/edi/resources.shtml>.

PRIOR TO BILLING DHS

READ your Oregon Administrative Rules! Pay special attention to the billing requirements. Be sure you have the most current information in effect for the date of service you are billing.

- The nursing facility Medicaid payment rules are in Oregon Administrative Rule (OAR) Chapter 411, Division 070. You can access these rules on the Seniors and People with Disabilities' (SPD) website, <http://www.oregon.gov/DHS/spd>. Click on “Adopted rules - numerical,” then “Chp. 411, Div. 070.”
- If you do not have Internet access, you may contact SPD at 1-800-232-3020 and ask to have provider guidelines mailed to you.

VERIFY resident eligibility date(s) of service. You must obtain prior-authorization from the local SPD office before providing nursing facility services to a Medicaid-eligible individual. Verify Medicaid eligibility and/or managed care enrollment with one of the electronic eligibility verification options.

- **Automated Voice Response**
Provides free, phone-based eligibility verification at 1-866-692-3864;
- **Secured Provider Web portal**
Provides free, real-time eligibility verification over the Web at
<https://www.or-medicaid.gov>
- **Electronic data interchange through the batch transaction called a 270 Inquiry and the 271 Response. Contact EDI Support for more details.**

The resident's name and number on the UB-04 claim form must match the name and number shown on the resident's Medical Care Identification Card (ID Card). A Medical Care ID number is always eight characters.

HELPFUL TIPS

- **DO NOT** enter information in any of the fields on the UB-04 unless instructed to do so in this guide. Entering invalid information on the UB-04 may cause the claim to deny or suspend.
- **MAKE SURE** that you billed third party resources (i.e. long-term care insurance) and reported the correct dollar amount in FL (Field Locator) 54.
- **ALWAYS** use the correct two (2)-digit third party resource (TPR) explanation code in the Remarks field when the resident has TPR, even if the TPR made no payment. Enter the appropriate code if the resident has more than one TPR available. The available TPR codes are located in **Appendix D**. Do not attach prior resource explanation of benefits (EOBs) to your claim form.
- **USE** commercially available “red form” versions of the UB-04 (not black and white copies).
- **ALWAYS** enter your DHS provider number in FL 57 and your National Provider Identifier (NPI) in FL 56. It is crucial that you list this information. An invalid or missing provider number could delay or deny your payment or make payment to the wrong provider.
- **CHECK** your claim form for legibility so that we can clearly read it. Avoid tiny print, print that overlaps onto a line, entering more than 22 lines per claim, and poorly handwritten claim forms. Complete only the required boxes. Handwritten claims must be filled out using blue or black ink.
- **EACH** UB-04 is a complete billing document. **DO NOT** carry-over totals from one UB-04 claim form to the next.
- **USE** a separate UB-04 claim form for each resident.
- **USE** an additional UB-04 claim form when there is a Break in Service, break in benefit package date ranges or change in level of care (see “Break in Service” and “Change Level of Care” below for more details).
- **READ** the explanation of benefit (EOB) codes on your Remittance Advice. They will tell you what the error is, and if you should re-bill or submit an Individual Adjustment Request form (DMAP 1036).
- **CONTACT** DHS Provider Services at 1-800-336-6016 for assistance in completing your UB-04 or other questions regarding an institutional claim.

BILLING CYCLES

Monthly Claims

Nursing facilities will bill on a monthly basis for resident who are identified in FL 17 as “Still a patient” (Patient Status Code 30). Claims can be submitted on a monthly basis for services provided in the previous month(s). All claims must be submitted on or after the 1st day of the month following the month in which services have been provided. Facilities will be allowed to bill for services up to 12 months after the date the service was provided. Facilities cannot bill for future dates of service.

Partial Month Claims

Facilities can bill for a partial month if the resident is discharged or if the resident expires before the end of the month.

Denied Claims

If a claim is denied you can re-submit the claim at any time, up to 18 months after the date the service was provided.

Suspended Claims

If a claim is suspended for DHS review you must wait for DHS to complete the review and the claim is in a finalized adjudicated status of paid, partially paid or denied before resubmission.

Financial Hold

If a claim is in a Financial Hold for DHS review you must wait for DHS to complete the review and the claim is in a finalized adjudicated status of paid, partially paid or denied before resubmission.

Paid Claims

If determined after a review of a Paid claim that DHS did not pay the appropriate amount you can submit an Individual Adjustment Request form indicating the needed change. See Appendix D – Claim Adjustments.

BREAK IN SERVICE

Any time a resident is out of the facility past midnight and is expected to return, it is considered a Break in Service. A Break in Service includes, but is not limited to, a hospitalization and/or a leave of absence (i.e. overnight or extended stay with family or friends).

Each time there is a Break in Service you must submit an additional UB-04 for each Statement Covers Period.

Example: 12/01/08 - Resident is admitted to the nursing facility
12/05/08 - Resident goes to the hospital and is expected to return
12/06/08 - Resident returns from the hospital and remains at the facility through the end of the month

In this example, you would be required to submit two (2) separate UB-04 claim forms; one UB-04 for the Statement Covers Period (dates of service) from 12/01/08 through 12/04/08; and an additional UB-04 for the Statement Covers Period from 12/06/08 through 12/31/08. (See **Appendix G** – Example 2).

NOTE: Any time there is a Break in Service, you must notify the local SPD office so the resident's "Plan of Care" in the MMIS system can be updated. If the dates of service or revenue code authorized in the system by SPD staff does not match the dates of service or revenue code on the claim, the claim may be suspended or be denied.

OTHER IMPORTANT INFORMATION

Client (Resident) Liability - Do not enter client liability on the UB-04 claim form. Client liability is automatically deducted by the MMIS from the total billed amount indicated in FL 47 (Total Charges), Line 23. If you enter the client liability on the UB-04, the MMIS will deduct the client liability twice. To adjust this, you would need to submit an Individual Adjustment Request form (DMAP 1036).

The amount of client liability deducted for each resident, for a specific Statement Covers Period will be reported back to the nursing facility on the remittance advice (RA). If the liability amount is different than what you were expecting, you will need to contact the local SPD office to verify the amount. If the liability amount needs to be adjusted, you will need to submit an Individual Adjustment Request (DMAP 1036) along with a copy of the Financial Planner form (458A) for the dates of service on the claim.

Level of Care (LOC) - Do not include the resident's level of care on the UB-04 claim form. The resident's level of care will be entered into the MMIS by the local or central SPD office. The level of care entered in the MMIS by SPD will set the maximum daily amount for which you are able to bill. If you bill more than the maximum allowable daily amount for any specific level of care, the claim will only pay the maximum allowable amount associated with the level of care authorized in the MMIS by SPD. If the level of care needs to be adjusted, you must notify the local or central SPD office. After receiving verification that the level of care has been updated in the MMIS, you will need to submit an Individual Adjustment Request (DMAP 1036).

Change in LOC - If the LOC changes in the middle of a billing (i.e. middle of the month), you will need to submit an additional UB-04 claim form each time the LOC changes.

Example: 10/01/08 Resident admitted at the Basic LOC
 12/15/08 Resident approved for Complex Medical Add-On LOC
 12/22/08 Resident goes back to Basic LOC

If the resident is not discharged, the facility would bill for all of October on one UB-04, and all of November on one UB-04.

In December, you would need to submit three separate UB-04 claim forms for this resident: one UB-04 for 12/1/08 through 12/14/08, one UB-04 for 12/15/08 through 12/21/08, and one UB-04 for 12/22/08 through 12/31/08. (See **Appendix F**, Example 3)

Note: In this example, the revenue code would stay the same on all three UB-04 claim

forms.

SKILLED NURSING FACILITY BILLING

DHS will pay on behalf of eligible residents the coinsurance rate established under Medicare, Part A, Hospital Care, for care rendered from the 21st day through the 100th day of care in a Medicare certified nursing facility. If a resident's Part A benefit is managed by a Medicare managed care plan, such as a Medicare Advantage Plan, DHS will pay coinsurance for days 21-100.

NOTE: Before billing DHS for coinsurance, the facility must bill the primary payer (Medicare or the managed care plan) responsible for the Medicare Part A benefit.

Submitting A SNF Coinsurance Claim

IMPORTANT NOTE:

In order for DHS to identify and track days 1 through 20 (which Medicaid does not pay) and days 21 through 100 (which Medicaid does pay), you must submit a claim to DHS for any and all days the resident is in your facility in a month for a continuous stay. DHS will calculate which days are covered by Medicaid and pay each claim accordingly. This may result in claims submitted to DHS that receive a 'zero paid' status.

For example:

If a resident is admitted to your facility on 1/20/2009, you must bill DHS for the month of January with dates of service 1/20/2009 through 1/31/2009. Your claim will 'zero pay' and 12 units will be counted towards the first 20 days that Medicaid does not pay.

When you bill for the month of February, DHS will calculate which days are covered by Medicaid and which days are not. Assuming no breaks in service, the first 8 units (2/1 to 2/8) will complete the first 20 day calculation and you will not be paid for those days. Medicaid will begin paying on 2/9 (day 21) and will continue to calculate up to day 100 as subsequent claims are submitted.

When there are breaks in service, DHS will calculate the number of days as described above based on each claim submitted. However, you must submit one individual Institutional Web claim form for each statement period, including statement periods that fall within days 1 through 20.

Important UB-04 Field Locators for SNF Claims

- In FL 07, enter “XOVR”. This code tells the MMIS that the claim is for a recipient that has Medicare coverage.
- In FL 35 (Occurrence Span), enter the date the resident was admitted to the hospital and the date the resident discharged from the hospital for the original qualifying stay.
- In FL 39 (Value Codes), enter the appropriate Value Code and the total Value Code Amount of coinsurance for which you are billing for the entire Statement Covers Period.
- In FL 47 (Total Charges) enter Medicare’s allowed amount or the managed care plan’s allowed amount for the entire Statement Covers Period.
- In FL 54 (Prior Payments), enter the total amount that Medicare or the managed care plan paid for the entire Statement Covers Period..

INTRODUCING THE UB-04 CLAIM FORM

The following pages introduce the UB-04 claim form and will identify the boxes that will be required when submitting your claim for payment processing. Boxes are identified as:

- FL - Field Locator
- FL Text - identifies the name of the field locator
- Billing Instructions - identifies the requirements needed to complete the field locator (box)

1										2										3a PAT. CNTL.# b. MED. REC.#										4 TYPE OF BILL																																																																															
																				5 FED. TAX NO.										6 STATEMENT COVERS PERIOD FROM THROUGH																																																																															
8 PATIENT NAME a										9 PATIENT ADDRESS a																																																																																																			
10 BIRTHDATE										11 SEX										12 DATE										ADMISSION 13 HR 14 TYPE 15 SRC 16 CHR 17 STAT										CONDITION CODES 22 23 24 25 26 27 28										29 ACOT STATE 30																																																											
31 OCCURRENCE CODE DATE										32 OCCURRENCE CODE DATE										33 OCCURRENCE CODE DATE										34 OCCURRENCE CODE DATE										35 OCCURRENCE SPAN FROM THROUGH										36 OCCURRENCE SPAN FROM THROUGH										37																																																	
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42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																																							
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58 INSURED'S NAME										59 REL.										60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.																																																																					
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REQUIRED FIELD LOCATORS

The Field Locators in the shaded boxes below are always mandatory. Non-shaded boxes are required when applicable or as indicated in the FL text boxes.

FL	FL Text	Billing Instructions
3a	Patient Control No.	If a resident's account number is provided in this box, DHS will print it on the Remittance Advice (RA).
4	Type of Bill	Enter the appropriate three (3)-digit code that identifies the type of service you are billing for. See <u>Appendix A</u> for a list of nursing facility specific codes.
6	Statement Covers Period	<p>Enter the beginning and ending dates of the billing period for the service covered by this claim. Use MMDDYY numeric format (example: 102806). Total days in this field must correspond to the number of units in FL 46.</p> <ul style="list-style-type: none"> • "From" date is the date services began. • "Through" date is the last paid date for the service period. If you are billing for an entire month and there is no Break in Service or change in level of care this is the last day of the month. <p>When a resident is discharged: For LTC Claims: The through date must one day prior to the day of discharge. For example, if a resident is admitted on 12/01/08 and discharged on 12/15/08, the through date will be 12/14/08. For SNF Claims: The through date must be the day of discharge. For example, if a resident is admitted on 12/01/08 and discharged on 12/15/08, the through date will be 12/15/08.</p> <p>NOTE: The Statement Covers Period must be a continuous period of time. A new UB-04 must be submitted each time there is a Break in Service.</p>
7	Required for SNF claims only.	<p>Enter "XOVR" to indicate the recipient has Medicare (or Medicare Managed Care) coverage.</p> <p>Note: Leave this field blank on ICF claims.</p>

FL	FL Text	Billing Instructions
8b	Patient Name	Enter the resident's name exactly as it is printed on the Medical Care Identification. DO NOT use "nicknames".
12	Admission Date	Enter the actual admission date. Use MMDDYY format (123008).
13	Admission Hour	Enter the hour of admission. Use military time from 00 to 24 (01 = 1 a.m., 13 = 1 p.m., 23 = 11 p.m., etc.).
16	Discharge Hour Required if applicable	Enter the hour of discharge. Use military time from 00 to 24 (01 = 1 a.m., 13 = 1 p.m., 23 = 11 p.m., etc.). Note: This field is only required if the resident discharged on the last day of the Statement Covers Period.
17	Patient Status	Enter the two (2)-digit code to indicate the resident's status at time of discharge. <u>For LTC Claims: Always use Patient Status Code 30.</u> If you use any other code, the last day in the Statement Covers Period will not be paid. <u>For SNF Claims:</u> If the resident is still a patient, use a patient status code of 30. If the resident has discharged, use a patient status code reflecting their discharge status.
31-36	Occurrence Codes/ Occurrence Span Required for SNF and PHEC claims	Enter the two (2)-digit code to indicate the type of occurrence and the date if the occurrence (i.e. date of incident) or the from and through date of the occurrence. Use MMDDYY format (123008). <ul style="list-style-type: none"> • 01 – Auto Accident (FL 31) • 04 – Employment-related accident (FL 31) • 70 – Qualifying Hospital Stay Dates for SNF (FL 35) Enter the date the resident was admitted to the hospital for the qualifying stay and the date the resident discharged from the hospital. Note: Occurrence code 70 and qualifying dates must be entered in FL 35 or FL 36 in order to receive payment for skilled nursing facility coinsurance or for the 20-day post hospital extended care (PHEC) benefit.

FL	FL Text	Billing Instructions
39-41	Value Codes Required for SNF claims	<p>Enter the appropriate value code(s) for Medicare Coinsurance and Deductible when Medicare is the primary payer.</p> <ul style="list-style-type: none"> • A1 (Deductible Payer A) - For the Part A or Part B deductible amount • A2 (Coinsurance Payer A) - For Part A or Part B coinsurance amounts. <p>Note: When Medicare coverage is present, it will normally be reported as "Payer A" on the UB-04. However, in situations where Medicare is "Payer B", use Value Codes "B1" and "B2" to report Medicare coinsurance and deductible. Failure to correctly report the Part A deductible may result in incorrect payment, suspended claims, or denied claims.</p>
42	Revenue Codes	<p>Enter the three (3)-digit code that most accurately describes the service provided. See <u>Appendix B</u> for a list of applicable Revenue Center Codes.</p> <p>Enter "001" in line 23 of this field to indicate the claim's total charges (entered in FL 47).</p>
43	Description	<p>Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43.</p>
44	HCPCS/RATE /HIPPS CODE	<p><u>LEAVE THIS FIELD BLANK.</u> If you enter the daily rate in this field, the claim will deny, suspend, or pay at the incorrect amount.</p>
46	Service Units	<p>Enter total days for each Revenue Center Code listed.</p> <ul style="list-style-type: none"> • One day equals one unit of service. • The total number of units must not exceed the total number of days in the "Statement Covers Period" in FL 6. <p>NOTE: Any time there is a Break in Service, you must submit a new UB-04. See Break in Service for more details.</p>
47	Total Charges	<p>Enter Medicare's allowed amount or the managed care plan's allowed amount for the entire Statement Covers Period. Enter the sum of all charges (lines 1) in</p>

FL	FL Text	Billing Instructions
		line 23 of this field.
50	Payer Identification	<p>Enter the name(s) of the payer organizations you are billing (up to three payers). Multiple payers should be listed in priority sequence according to the priority in which the provider expects to receive payment from these payers.</p> <ul style="list-style-type: none"> • First line, 50a is always for Medicare. • Second line, 50b is always for the Secondary Payer. • Third line, 50c is always Medicaid. <p>NOTE: If DHS is the only payer, enter 'Medicaid' on Line C. If Medicare is the primary payer, enter 'Medicare' on Line A and 'Medicaid' on Line C.</p>
54	Prior Payments	<p>Enter actual amount of any payments you received from Third Party Resources (TPR). Use the line that corresponds to the line used for DHS in FL 50.</p> <ul style="list-style-type: none"> • If Medicare paid, show the actual amount that Medicare or the managed care plan paid for the entire Statement Covers Period. • Do not list write-offs, what Medicaid previously paid, or Medicare coinsurance. • Use this field if a resident has long-term care insurance.
56	NPI	Enter your ten (10)-digit National Provider Identifier.
57	Other Provider ID	Enter your DHS provider number on the line that corresponds to the line used for DHS in FL 50. DHS will pay this provider.
60	Insured's Unique ID	<p>Enter the resident's eight (8)-digit Medicaid Identification Number (Prime Number). Use the line that corresponds to the line used for DHS in FL 50.</p> <ul style="list-style-type: none"> • If there are other insurance numbers shown, such as Medicare, then the Medicaid identification number should appear last in the field. <p>Note: The prime number is printed on the Medical Care Identification Card, or you can obtain it through the Automated Voice Response, Web Portal, or SPD local office.</p>
67	Principal	Enter the primary diagnosis/condition of the

FL	FL Text	Billing Instructions
	Diagnosis Code	<p>resident by entering the current ICD-9-CM code. The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records.</p> <ul style="list-style-type: none"> • Carry out code to its highest degree of specificity (diagnosis codes are 3, 4 or 5 digits). • DO NOT enter the decimal point.
67A – 67D	Other Diagnosis Codes	<p>Enter up to four (4) additional ICD-9-CM codes, as appropriate. You can enter additional diagnosis codes for conditions that:</p> <ul style="list-style-type: none"> • Co-exist at the time of admission. • Develop subsequently. • Affect treatment received and/or length of treatment.
69	Admit Diagnosis	<p>Enter the admitting diagnosis/condition of the resident by entering the ICD-9-CM code.</p>
78	Other Physician ID	<p>For the resident’s Primary Care Manager (PCM), list the ten (10)-digit NPI, followed by the DHS provider number of the PCM.</p>
80	Remarks	<p>If the resident has other medical coverage, enter the appropriate two (2)-digit third party resource (TPR) explanation code. See <u>Appendix D</u> for TPR explanation codes.</p>

APPENDIX A

Field Locator (FL) 4 - Type of Bill Codes

The Type of Bill code is a three (3)-digit code used to indicate the type of facility (first digit), type of care provided (second digit) and frequency of services (third digit) on the UB-04.

Intermediate Care Facility (ICF) - The codes in this column are to be used when a facility has provided Medicaid long-term care to a resident in a nursing facility.

Skilled Nursing Facility (SNF) - The codes in this column are to be used when the facility has provided short-term skilled nursing facility services to a resident. This includes Medicare Part A (or Medicare Managed Care) stays only.

Swing-Beds (Swing) - The codes in this column are to be used by hospitals that have a Medicaid contract to provide swing bed services to Medicaid clients.

ICF	SNF	Swing	Description
651	211	181	Admit through Discharge Claim: Encompasses an entire span of service (admission through discharge) for which the facility expects reimbursement.
652	212	182	First Claim: Use this code when the resident is admitted to the facility and this is the first of an expected series of claims.
653	213	183	Continuing Claim: Use when one or more claims for the span of service have already been submitted, and further claims are expected to be submitted at a later date.
654	214	184	Last Claim: Use this code when the resident is discharged from the facility and this is the last in a series of claims. The “through” date of this claim (FL 6) is the discharge date or date of death for this service span.

APPENDIX B

Field Locator 42 - Revenue Codes

Type of Care	Revenue Code	Level of Care	Description	Old LOC Crosswalk Reference
ICF/LTC	100	01	Basic	SS
ICF/LTC	100	02	Pediatric	HA
ICF/LTC	100	03	Complex Medical Add-On	NH
ICF/LTC	100	04	Enhanced Care	NHH
ICF/LTC	100	05	Outlier	---
ICF/LTC	100	06	Out of State Nursing Facility	SS or NH
Swing-Bed	101	N/A	Hospital Swing-Bed (Short Stay Only)	NH
20 day PHEC	101	N/A	Post Hospital Extended Care	SSH
SNF	022	N/A	Medicare (no co-insurance days)	Z EC
SNF	022	N/A	Medicare (w/ co-insurance days)	V EC

Level of Care – These codes are provided for reference only. **Do not include LOC codes on the UB-04.**

OLD Level of Care (LOC) Crosswalk Reference – This section of the chart shows the LOC codes used in the previous MMIS system to help facilities identify the correct revenue code to use in the replacement MMIS system. This crosswalk has been included as a REFERENCE ONLY.

APPENDIX C

FL 80 - Third Party Resource (TPR) Explanation Codes

Single Insurance Coverage

Use in Field Locator (FL) 80 on the UB-04 form. Use a single insurance code when the resident has only one insurance policy in addition to Medicaid.

UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Resident Not Covered by Insurance Policy
IC	Insurance Coverage Canceled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Resident
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Resident
RP	Requested Information Not Received by Insurance from Policyholder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance Mandated Under Administrative/Court Order Through an Absent Parent-and Not Paid Within 30 Days
OT	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

Multiple Insurance Coverage

Use in Field Locator (FL) 80 on the UB-04 form. Use a multiple insurance code when the resident has more than one insurance policy in addition to Medicaid.

MP	Primary Insurance Paid – Secondary Paid
SU	Primary Insurance Paid – Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid – Secondary Service Not Covered
SC	Primary Insurance Paid – Secondary Resident Not Covered
ST	Primary Insurance Paid – Secondary Canceled/Terminated
SL	Primary Insurance Paid – Secondary Lapsed or Not in Effect
SP	Primary Insurance Paid – Secondary Payment Went to Resident
SH	Primary Insurance Paid – Secondary Payment Went to Policyholder
SA	Primary Insurance Paid – Secondary Denied - Service Not Authorized
SE	Primary Insurance Paid – Secondary Denied - Service Not Considered Emergency
SF	Primary Insurance Paid – Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Insurance Paid – Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Resident
MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

APPENDIX D

CLAIM ADJUSTMENTS (DMAP 1036)

To request an adjustment to a claim that has been processed to a PAID status for a specific “Statement Covers Period,” you will need to submit an Individual Adjustment Request form (DMAP 1036). An electronic version of this form is available on the DHS forms website by going to: <http://dhsforms.hr.state.or.us/forms/>.

Required Fields: Fields 4 through 10, and 17 are all required fields. All other fields are required when applicable.

Mail the Individual Adjustment Requests to the address below:

**Division of Medical Assistance Programs
P.O. Box 14954
Salem, Oregon 97309**

DHS also accepts claim adjustments through the use of the web portal (not currently available for co-insurance claims) and the electronic data interchange.

APPENDIX E

Example 1 – Long-term care resident (ICF)

- 11/01/08 – Resident is admitted to the facility at the Basic level of care (basic bundled/all inclusive rate = \$198.17/day).
- 12/31/08 – Resident remains at the facility. From 11/01/08 through 12/31/08, there was no Break in Service or change in level of care.
- Facility is billing for the entire month of December 2008.

In this example, the facility would bill for December on one (1) UB-04 claim form. Since the resident did not discharge from the facility on 12/31/08, you would use Patient Status Code 30 (still a resident) in order to get paid for the last day in the Statement Covers Period.

1 ABC Nursing Home Address City, State		2		3 Example 1		4 FACILITY ID X123400		5 STATE OF BILL 653			
6 PATIENT NAME Doe, John				7 PATIENT ADDRESS				8 FEDERAL NO. 120108		9 COVERED PERIOD THROUGH 123108	

10 ICD-9-CM 110108		12 ICD-9-CM 17		13 ICD-9-CM 30		14 CONDITION CODES 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29						30 ADMIT DATE			
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38 OCCURRENCE DATE	
39 CODE		40 CODE		41 CODE		42 CODE		43 CODE		44 CODE		45 CODE		46 CODE	
47 VALUE CODES		48 VALUE CODES		49 VALUE CODES		50 VALUE CODES		51 VALUE CODES		52 VALUE CODES		53 VALUE CODES		54 VALUE CODES	

55 ICD-9-CM	56 DESCRIPTION	57 HCPCS / ICD-9 / ICD-10 CODE	58 DRUG CODE	59 DRUG UNITS	60 TOTAL CHARGE	61 ADJUSTED CHARGE
100	Room and Board			31	6,143.27	
001 PAGE ____ OF ____ CREATION DATE TOTALS 6,143.27						

62 PRICE NAME Medicaid		63 HEALTH PLAN ID		64 PAYER		65 PAYER TYPE		66 PAYER PAYMENT		67 EST AMOUNT DUE		68 PAYOR S*****	
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69 INSURER'S NAME		70 PLAN		71 INSURER'S MEMBER ID AA###A#B		72 GROUP NAME		73 INSURER'S GROUP NO.	
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74 TREATMENT AUTHORIZATION CODES				75 DOCUMENT CONTROL NUMBER				76 EMPLOYER NAME			
----------------------------------	--	--	--	----------------------------	--	--	--	------------------	--	--	--

77 ADMIT CODE 7837		78 ICD-9-CM 7837		79 ICD-9-CM 7837		80 ICD-9-CM 7837		81 ICD-9-CM 7837		82 ICD-9-CM 7837		83 ICD-9-CM 7837		84 ICD-9-CM 7837	
85 PHYSICIAN CODE		86 PHYSICIAN CODE		87 PHYSICIAN CODE		88 PHYSICIAN CODE		89 PHYSICIAN CODE		90 PHYSICIAN CODE		91 PHYSICIAN CODE		92 PHYSICIAN CODE	
93 OTHER		94 OTHER		95 OTHER		96 OTHER		97 OTHER		98 OTHER		99 OTHER		00 OTHER	

Example 2 – LTC Resident with a Break in Service

- 12/01/08 - Resident is admitted to at Basic level of care (\$198.17/day).
- 12/05/08 - Resident goes to the hospital and is expected to return.
- 12/06/08 - Resident returns from the hospital at the Basic level of care and remains at the facility through the end of the month.

In this example, you would be required to submit two (2) separate UB-04 claim forms; one UB-04 for the dates of service from 12/01/08 through 12/04/08 (Example 2a); and an additional UB-04 for the dates of services from 12/06/08 through 12/31/08 (Example 2b).

1 ABC Nursing Home Address City, State		2 Example 2a		3A POC CONT. #	X123400		4 TYPE OF BILL	651
5 PATIENT NAME				6 FRONT ADDRESS				7
8 Doe, John								9
10 IDENTIFIER		11 SCA	12 DATE	13 ADMISSION 13.01 14 TYPE	15.01	16.01	17 START	18 END
120108			18				18	30
19 OCCURRENCE CODE		20 OCCURRENCE DATE	21 OCCURRENCE CODE	22 OCCURRENCE DATE	23 OCCURRENCE CODE	24 OCCURRENCE DATE	25 OCCURRENCE CODE	26 OCCURRENCE DATE
27 OCCURRENCE FROM		28 OCCURRENCE THROUGH		29 OCCURRENCE FROM		30 OCCURRENCE THROUGH		31
32 CODE		33 VALUE CODES AMOUNT	34 CODE	35 VALUE CODES AMOUNT	36 CODE	37 VALUE CODES AMOUNT	38 CODE	39 VALUE CODES AMOUNT

40 RRV CD	41 DESCRIPTION	42 PRICE / UNIT / HPPS CODE	43 RRV UEN	44 RRV UNITS	45 TOTAL CHARGE	46 RRV CHARGE CODE	47
100	Room and Board			4	792.68		
				TOTALS	792.68		

001	PAGE	OF	CREATION DATE	792.68	792.68			
48 PAYER NAME		49 HEALTH PLAN ID	50 POC	51 PLAN ID	52 POC PAYMENTS	53 EST AMOUNT DUE	54 SP	55 OTHER PRVID
Medicaid								8#####

56 MEMBER'S NAME	57 POB	58 INSURER'S MEMBER ID	59 GROUP NAME	60 INSURER'S GROUP ID
		AA###A#B		

61 TREATMENT AUTHORIZATION CODES	62 DOCUMENT CONTROL NUMBER	63 EMPLOYER NAME

64	7837	A	B	C	D	E	F	G	H	I
		J	K	L	M	N	O	P	Q	

65 ADMIT CC	7837	66 FRONT NUMBER CC	67	68	69	70	71	72
73 REFERRAL PROCEDURE CODE	74	75 OTHER PROCEDURE CODE	76	77 OTHER PROCEDURE CODE	78	79 OTHER PROCEDURE CODE	80	81
82 READING	83	84	85	86	87	88	89	90

Example 3 – Change in Level of Care

- 10/01/08 Resident admitted to the facility at Basic level of care (\$198.17/day).
- 12/15/08 Resident approved for Complex Medical Add-On level of care (\$277.44/day).
- 12/22/08 Resident goes back to Basic level of care (\$198.17/day).

In this example, the facility would bill for all of October 2008 on one UB-04, and all of November 2008 on one UB-04 (see Example 1).

For the month of December, you would need to submit three separate UB-04 claim forms for this resident. One UB-04 for 12/1/08 through 12/14/08 (Example 3a), one UB-04 for 12/15/08 through 12/21/08 (Example 3b), and one UB-04 for 12/22/08 through 12/31/08 (Example 3c).

Example 4: SNF Billing – Coinsurance

- 11/25/08 through 11/30/08 – Resident is in the hospital (Qualifying Dates of Stay).
- 12/01/08 – Resident is admitted to the Skilled Nursing Facility (SNF).
- 12/31/08 – Resident is discharged home.
- Medicare is the primary payer source.
- The Medicare rate is \$300.00 per day for the entire stay.
- The Medicare coinsurance is \$128.00 per day.

In this example, the resident is in the facility a total of 31 days. However, the day of discharge is not a covered day. Therefore, there are a total of 30 covered days and the last day in the Statement Covers Period is 12/31/08.

The total charges for this stay are \$5000.00.

Medicare pays for days 1-20 (12/01/08 through 12/20/08) in the amount of \$3720.00.

During days 21 through 30, Medicare pays all but the coinsurance amount (\$128.00 per day). **The facility would bill DHS for the coinsurance amount from 12/21/08 through 12/30/08, or \$1280.00.**

Important Field Locators for SNF Billing:

FL 07 – Enter “XOVR”

FL 39 – Enter the total amount (coinsurance amount) you are billing DMAP for the entire Statement Covers Period - \$1,280.00.

FL 47 – Enter Medicare’s allowed amount or the managed care plan’s allowed amount for the entire Statement Covers Period (12/21/08 through 12/30/08) - \$5,000.00.

FL 54 – Enter the total amount Medicare paid for the entire Statement Covers Period - \$3,720.00.

1 ABC Nursing Home Address City, State	2	3. PAT. CHTR X123400	4 TYPE OF BILL 211																		
Example 4 - SNF Claim		5. FED. TAX NO.	6. STATEMENT COVERS FROM 120108	7 123108	8 XOVR																
		9. PATIENTS NAME a	9. PATIENTS ADDRESS b	c	d																
10 BIRTHDATE	11 SEX	12 DATE 120108	13 HR 16	14 TYPE	15 SRG	16 DHR	17 STAT 17 01	18	19	20	21	22	23	24	25	26	27	28	29	30	
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE FROM	36 OCCURRENCE THROUGH	37	70	112508	113008												
38	39 CODE	40 VALUE CODES AMOUNT	41 CODE	42 VALUE CODES AMOUNT	43 CODE	44 VALUE CODES AMOUNT	A2	1280.00													
42 REV CD 022	43 DESCRIPTION Medicare Coinsurance	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS 30	47 TOTAL CHARGES 5000.00	48 NON COVER CHARGES	49														
001	PAGE 0 OF 0	CREATION DATE	TOTALS	5000.00	0.00																
50 PAYER NAME Medicare Secondary Payer Medicaid	51 HEALTH PLAN ID	52 INFO	53 PRIOR PAYMENTS 3720.00	54 EST. AMOUNT DUE 1280.00	55 NPI 8#####	56 NPI 8#####	57 OTHER PRVID	58	59 PREL	60 INSURER'S UNIQUE ID Medicare Number AB###A#B	61 GROUP NAME	62 INSURANCE GROUP NUMBER	63 TREATMENT AUTHORIZATION CODE	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	66	67	68	69	70	71
72 ADMIT DX 7837	73 PATIENT REASON DX	74 PPS CODE	75 ECI	76 ATTENDING NPI	77 QUAL	78 LAST	79 FIRST	80	81	82	83	84	85	86	87	88	89	90	91	92	
74 PRINCIPAL PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 OTHER PROCEDURE DATE	77 OTHER PROCEDURE DATE	78 ATTENDING NPI	79 QUAL	80 LAST	81 FIRST	82	83	84	85	86	87	88	89	90	91	92	93	94	
74 PRINCIPAL PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 OTHER PROCEDURE DATE	77 OTHER PROCEDURE DATE	78 OPERATING NPI	79 QUAL	80 LAST	81 FIRST	82	83	84	85	86	87	88	89	90	91	92	93	94	
80 REMARKS	81 a	82	83	84 OTHER NPI	85 QUAL	86 LAST	87 FIRST	88	89	90	91	92	93	94	95	96	97	98	99	100	
	b			OTHER NPI	QUAL	LAST	FIRST														
	c			OTHER NPI	QUAL	LAST	FIRST														
	d			OTHER NPI	QUAL	LAST	FIRST														

APPENDIX F

Contact Information

Automated Voice Response (AVR) To verify client eligibility, benefit packages, managed care coverage, primary care manager, or limited service information. <ul style="list-style-type: none">• Available Monday through Saturday - 3 a.m. to midnight, Sunday - 6 a.m. to 7 p.m.	1-866-692-3864
DHS Provider Services Unit For general claims inquiry or help filling out a UB-04. <ul style="list-style-type: none">• Available Monday through Friday - 8 a.m. to 5 p.m.	1-800-336-6016
DMAP Claims Unit For Individual Adjustment Requests Process. <ul style="list-style-type: none">• Available Monday through Friday - 8 a.m. to 5 p.m.	1-888-690-9888
Standard Register Company, Forms Division To order “red” UB-04 paper claim forms. <ul style="list-style-type: none">• Note: UB-04 paper claim forms are also available through local business forms suppliers. Ask for the “red” forms.	1-800-755-6405
DHS EDI Support For information about the electronic claims submission process.	1-888-690-9888
Nursing Facility Policy and Provider Support For questions related to the nursing facility payment rules, licensing rules, Medicare or Medicaid certification, or the Nursing Facility Billing Guide. <ul style="list-style-type: none">• Available Monday through Friday - 8 a.m. to 5 p.m.	1-800-232-3020

Mailing Addresses:

UB-04

Division of Medical Assistance Programs
PO Box 14956
Salem, OR 97309

Individual Adjustment Request (DMAP 1036)

Division of Medical Assistance Programs
P.O. Box 14954
Salem, OR 97309