# Hospital Inpatient "Crossover" UB-04

Claim form billing instructions for the Department of Human Services



### Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the UB-04 billing form correctly the first time. This presentation is to be used in conjunction with General Rules, your provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~DHS~

### MMIS

- 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.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted.

### **Claims Processing**

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

### About the crossover

- If the recipient has Medicare Part A, you must bill Medicare first.
- Medicare will automatically send your claim to DMAP, this is called a "crossover".
- Do not submit claims to DMAP until they have been billed to and adjudicated by Medicare.

### Before you bill

- Read your provider guidelines.
- Verify recipient eligibility on the date of service.
- Make sure you bill all prior resources first. DHS is the payer of last resort.
- Use commercially available versions of the UB-04.

### A few tips!

- When submitting handwritten claim forms, you must use blue or black ink, never use red ink.
- Make sure your hand writing is legible.
- If possible, submit no more than twenty-two lines of services per claim form. All inpatient charges must be billed on one claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

### Form suppliers

- The UB-04 form is not supplied by DHS.
- Forms are available by contacting one of the following:
  - Local business forms suppliers
  - Standard Register Company, Forms Division (800-755-6405)

### Services billed on the UB-04

#### **Institutional Providers**

- Free Standing Kidney Dialysis
- Home Health
- Hospice
- Hospital

### Services billed on the UB-04

- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

# Introducing the UB-04



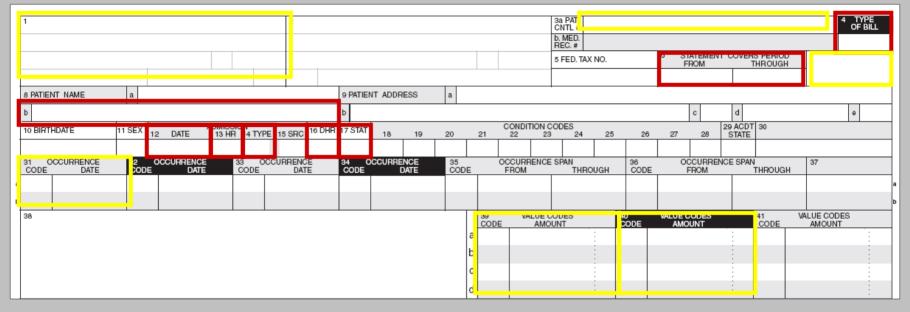
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### UB-04

• Not sure if you are using the correct form?

The bottom left corner will look like this.

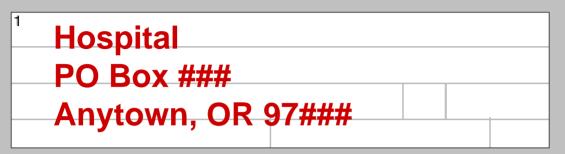
### **Top section**



Red = Required

Yellow = Optional

# **Box 1 - Optional**



#### **Billing Provider Information**

 Enter the name and address of the Hospital that is requesting to be paid for the services rendered.

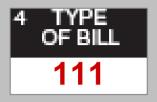
# **Box 3a - Optional**

#### 3a PAT. CNTL # X123400

#### **Patient Account Number**

- Enter your recipient account number here.
- This box allows up to twelve characters.
- This number will appear on your Remittance Advice (RA).

### **Box 4 - Required**



### Type of Bill

- Enter the three-digit numeric code to identify the type of claim you are billing.
  - 111 Inpatient (including patients with Medicare Part A only)
  - 121 Inpatient (including patients with Medicare Part B only)

### **Box 6 - Required**

6	STATEMENT FROM	COVERS PERIOD THROUGH
	040107	040707

#### **Statement Covers Period**

- Enter the beginning and ending dates of services covered by this claim.
- This box must list numeric dates of service.
- The from date is the date of admission.
- The through date is the date of discharge, transfer or expiration.

# **Box 7 - Optional**

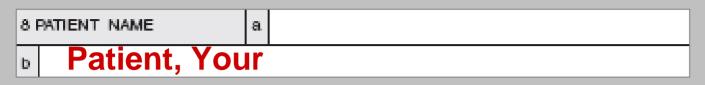
### XOVR

7

#### **Crossover Indicator**

- If the recipient has Medicare Part A, enter "XOVR".
- Do not enter "XOVR" if the recipient has Medicare Part B only.

### **Box 8b - Required**



#### **Recipient Name**

- Enter the recipient's name exactly as it is printed on the Medical Care Identification.
- Use the recipient's last name first.
- Do not use nicknames.

# **Box 12 - Required**



#### **Admission Date**

 Enter the actual date of admission, even if the recipient was not eligible on the date admitted.

# **Box 13 - Required**

# 13 HR

#### **Admission Hour**

- Enter the hour of admission in military time.
- Example:
  - 01 1:00 a.m.
  - 10 10:00 a.m.
  - 14 2:00 p.m.
  - 23 11:00 p.m.

# **Box 14 - Required**



### **Admission Type**

- Enter the type of admission.
- Example:
  - 1 Emergent
  - 2 Urgent
  - 3 Elective
  - 4 Newborn

# **Box 16 - Required**



#### **Discharge Hour**

- Enter the discharge hour in military time.
- Example:
  - 01 1:00 a.m.
  - 10 10:00 a.m.
  - 14 2:00 p.m.
  - 23 11:00 p.m.

# **Box 17 - Required**



#### **Discharge Status**

- Enter the recipient discharge status.
- Example:
  - 01 To home or self care
  - 02 To another acute care hospital
  - 03 To skilled nursing facility
  - 04 To intermediate care facility
  - 05 To another type of institution
  - 06 To home under care of Home Health
  - 07 Left against medical advice
  - 08 To home under care of Home Enteral/Parenteral
  - 20 Expired

# **Box 31 - Optional**

31 OCCURRENCE								
CODE	DATE							

#### **Accident Occurrence**

- If this claim is a result of an accident, enter one of the following codes and the date of the occurrence.
  - 01 Auto accident
  - 04 Employment related accident
- Pursue all prior resources first.
- DMAP is the payer of last resort.

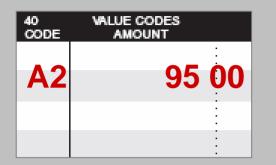
### **Box 39 - Optional**

39 CODE	VALUE CODES AMOUNT
<b>A1</b>	695 00

#### Value Codes

- Enter value code "A1" to identify Medicare Part A deductible.
- Enter Medicare Part A deductible dollar amount.

### **Box 40 - Optional**



#### Value Codes

- Enter value code "A2" to identify Medicare Part A coinsurance.
- Enter Medicare Part A coinsurance dollar amount.

### **Middle section**

2 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	8 NON-COVERED CHARGES	49
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Red = Required

# **Box 42 - Required**

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#### **Revenue Center Codes**

- Enter a three-digit revenue center code which most accurately describes the service provided.
- Use an accommodation day revenue center code if the recipient was admitted, discharged, transferred or expired on the same day.
  - Do not use the same revenue center code twice.
- Refer to your Hospital supplemental for a complete list of revenue center codes.

# **Box 46 - Required**

# 46 SERV. UNITS 6 29 8 2 7 8

#### **Service Units**

- Enter the number of days or units for each related revenue center code listed.
- One visit equals one unit of service.
- One supply item equals one unit of service.
- When billing with an accommodation day, never count the discharge date as a unit.

# **Box 47 - Required**

#### **Total Charges**

- Enter the total usual and customary charge for each related revenue center code listed.
- Do not list credits.
- Do not use dashes.

# **Total - Required**



### **Total Charges**

- Enter the total amount billed.
- Add the charges as indicated from column 47.
- Do not list credits.
- Do not use dashes.
- Each claim form is a separate document, and is to be totaled as such.

### **Bottom section**

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Red = Required

Yellow = Optional

# **Box 50 - Optional**

50 PAYER NAME

- Primary payer
- Secondary payer
- Tertiary payer

### **Payer Name**

 Enter the names of up to three payer organizations in order.

> Example: If Medicaid is primary, enter on line A. If Medicaid is secondary, enter on line B. If Medicaid is tertiary payer, enter on line C.

# **Box 54 - Optional**



#### **Prior Payments**

- Enter the total amount paid by other third party resource's.
- Do not list write-off's.
- Do not include how much DHS previously paid.
- Do not include copayments.
- Correspond the placement as outlined in box 50 instructions.

### **Box 56 - Required**

56 NPI ##########

#### **National Provider Identifier (NPI)**

 Enter the ten-digit NPI of the Hospital billing for services rendered.

# **Box 57 - Required**

57	
OTHER	#####
PRV ID	

#### **Provider Number**

- Enter the six-digit (DHS issued) provider number of the Hospital billing for services rendered.
- Do not list other payer provider numbers.
- Correspond the placement number as outlined in box 50 instructions.

### **Box 60 - Required**

60 INSURED'S UNIQUE ID

X X # # # X # X

#### **Recipient ID Number**

- Enter the recipient's eight-character prime identification number.
- Enter the number exactly as it appears on the Medical Care Identification.
- Correspond the placement as outlined in box 50 instructions.

# **Box 63 - Optional**

63 TREATMENT AUTHORIZATION CODES

А

В

C

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#### **Treatment Authorization**

- If the service you provided requires prior authorization (PA), enter the nine-digit prior authorization number that was issued for the service.
- Only use one prior authorization number per claim form.
- Correspond the placement as outlined in box 50 instructions.

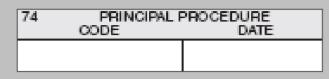
# **Box 66 - Required**



#### **Diagnosis Code**

- Enter the recipient's diagnosis/condition.
- The diagnosis code must be the reason chiefly responsible for causing this hospitalization.
- You may enter up to five codes if necessary by listing them in box 67 - 67D.
- The diagnosis codes must be carried out to its highest degree of specificity.
- Do not use the decimal point.

# **Box 74 - Optional**



#### **Principal Procedure**

- This box is required if a procedure was performed.
- Enter the ICD-9-CM procedure code which best identifies the procedure completed.
- The principle procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes.

# **Box 78 - Optional**

INF1 #########

**Referring Provider ID** 

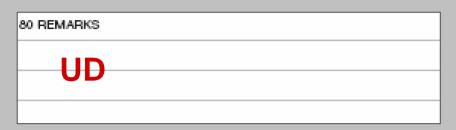
78 OTHER

 This box is only required when the recipient is referred by their Primary Care Manager (PCM) or Physician Care Organization (PCO).

QUAL

- Enter the ten-digit NPI of the referring PCM or PCO.
- Enter the six-digit (DHS issued) provider number of the referring PCM or PCO.
- If the recipient is not referred by the PCM or PCO, leave this box blank. Rendering provider numbers or six-nines are no longer required.

# **Box 80 - Optional**



#### **Third Party Resource**

- If the recipient has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
- A code must be listed when the other insurance did not make a payment, and always when the recipient has more than one other insurance carrier.
- TPR codes can be found in your provider rulebook supplemental, or on the following slides.

# Single carrier TPR codes

UD	Service under deductible							
NC	Service not covered by insurance policy							
PN	Patient 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 patient							
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							
	Single carrier TPR codes continued on next slide							

# Single carrier TPR codes

MB	Maximum benefits used for diagnosis/condition						
RI	Requested information not received by insurance from patient						
RP	Requested information not received by insurance from policyholder						
MV	Motor Vehicle Accident Fund (MVAF) maximum benefits exhausted						
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days						
ОТ	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)						

### Multiple carrier TPR codes

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 patient 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 patient
	Multiple carrier TPR codes continued on next two slides

### Multiple carrier TPR codes

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 – reque information not received from policyholder				
	Multiple carrier TPR codes continued on next slide			

### Multiple carrier TPR codes

SR	Primary insurance paid – secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
МО	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

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### Resources



#### Where to mail your claim

Mail your UB-04 claim form to:

DMAP PO Box 14956 Salem, OR 97309-4957

### Who to call if you need help

- Contact DHS' DMAP Provider Services if you need assistance or questions concerning your UB-04 claim form.
- They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

# Thank You!

