

Nursing Facility UB-04 Paper Billing Guide



Oregon Medicaid Nursing Facilities
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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 an Internal Control Number (ICN).
- 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 on an Electronic Document Management System (EDMS).

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

The system performs daily edits for presence and validity of data. 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. The system directs the claim to DHS staff for specific medical or administrative review. The status of this type of claim is known as a suspense (suspended) claim.

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 claims that have been processed.

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. If possible, avoid using 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.

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

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

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>

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 TRP made not 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) whenever possible.
- **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 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.

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 system will deduct the client liability twice. To adjust this, you would need to submit an Individual Adjustment Request (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).

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.

Important UB-04 Field Locators for SNF Claims

- In FL 07, enter "XOVR". This code tells the MMIS that the claim is a crossover claim.
- 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 the total amount you billed Medicare or the managed care plan 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.
- In FL 35 (Occurrence Span), enter the date the resident was admitted to the hospital and the date the resident discharged from the hospital.

INTRODUCING THE UB-04 CLAIM FORM

The following pages introduces 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)

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	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. <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 are no Break in Service or change in level of care this is the last day of the month. When a resident is discharged, 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. <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.	Enter "XOVR" to indicate the claims is a Medicare (or Medicare Managed Care) crossover claim. Note: Leave this field blank on ICF claims.
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.).

FL	FL Text	Billing Instructions
16	Discharge Hour Required if applicable	<p>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.).</p> <p>Note: This field is only required if the resident discharged on the last day of the Statement Covers Period.</p>
17	Patient Status	<p>Enter the two (2)-digit code to indicate the resident's status at time of discharge.</p> <p><u>Always use Patient Status Code 30 on nursing facility claims.</u> If you use any other code, the last day in the Statement Covers Period will not be paid.</p>
31-36	Occurrence Codes/ Occurrence Span Required for SNF and PHEC claims	<p>Enter the two (2)-digit code to indicate the type of occurrence and the date if the occurrence (i.e. date of accident) or the from and through date of the occurrence. Use MMDDYY format (123008).</p> <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 and the date the resident discharged from the hospital. <p>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.</p>
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</p>

FL	FL Text	Billing Instructions
		"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.
42	Revenue Codes	<p>Enter the three (3)-digit code that most accurately describes the service provided. See <u>Appendix C</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	Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43.
44	HCPCS/RATE /HIPPS CODE	<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.
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	Enter the usual and customary charge for each Revenue Center Code listed. Multiply the total number of days billed for each line by the daily rate to get a total for each line item. Enter the sum of all charges (lines 1-22) in line 23 of this field.

FL	FL Text	Billing Instructions
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 the Primary Payer Name. • Second line, 50b is the Secondary Payer Name. • Third line, 50c is the Tertiary Payer Name. <p>NOTE:</p> <ul style="list-style-type: none"> • If DHS is the only payer, enter DHS/Medicaid on Line A. • DHS is the payer of last resort. Any resources billed prior to billing DHS should be listed first.
54	Prior Payments	<p>Enter the 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 Medicare payment. • 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 Diagnosis Code	<p>Enter the primary diagnosis/condition of the 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>

FL	FL Text	Billing Instructions
		<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	Enter the admitting diagnosis/condition of the resident by entering the ICD-9-CM code.
78	Other Physician ID	For the resident’s Primary Care Manager (PCM), list the ten (10)-digit NPI, followed by the DHS provider number of the PCM.
80	Remarks	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.

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 UB-04 claim that has been processed 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

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 PAGE 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 ADJUST START	
16 OCCURRENCE DATE		17 OCCURRENCE DATE		18 OCCURRENCE DATE		19 OCCURRENCE DATE		20 OCCURRENCE DATE		21 OCCURRENCE DATE		22 OCCURRENCE DATE	
23 VALUE CODES		24 VALUE CODES		25 VALUE CODES		26 VALUE CODES		27 VALUE CODES		28 VALUE CODES		29 VALUE CODES	

30 ICD-9-CM	31 DESCRIPTION	32 HCPCS / ICD-9 / ICD-10 CODE	33 QUANTITY	34 XREFS UNITS	35 TOTAL CHARGE	36 ADJUSTED CHARGE
100	Room and Board			31	6,143.27	
					TOTALS	6,143.27

001 PAGE OF		CREATION DATE		TOTALS		6,143.27	
37 PRICE NAME Medicaid		38 HEALTH PLAN ID		39 PRICE PAYMENTS		40 EST AMOUNT DUE	
41 OTHER PROVIDED		42		43		44	

45 INSURER'S NAME		46 PLAN		47 INSURER'S MEMBER ID AA###A#B		48 GROUP NAME		49 INSURER'S GROUP NO.	
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50 TREATMENT AUTHORIZATION CODES				51 DOCUMENT CONTROL NUMBER				52 EMPLOYER NAME			
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53 ADMIT CODE 7837		54 ICD-9-CM 7837		55 ICD-9-CM		56 ICD-9-CM		57 ICD-9-CM		58 ICD-9-CM		59 ICD-9-CM		60 ICD-9-CM	
61 PHYSICIAN CODE		62 PHYSICIAN CODE		63 PHYSICIAN CODE		64 PHYSICIAN CODE		65 PHYSICIAN CODE		66 PHYSICIAN CODE		67 PHYSICIAN CODE		68 PHYSICIAN CODE	
69 OTHER		70 OTHER		71 OTHER		72 OTHER		73 OTHER		74 OTHER		75 OTHER		76 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. # 3B POC EXT. #	3C X123400	4 TOTAL OF BILLS 651
5 PATIENT NAME 6 Doe, John				7 FRONT ADDRESS 8		9
10 IDENTIFIER 11 BOX 12 DATE 13 120108		14 ADMISSION 15 EP 16 TYPE 17 18		18 30		19

20 OCCURRENCE CODE		21 OCCURRENCE DATE		22 OCCURRENCE CODE		23 OCCURRENCE DATE		24 OCCURRENCE CODE		25 OCCURRENCE DATE		26 OCCURRENCE CODE		27 OCCURRENCE DATE	

28 RRV CODE	29 DESCRIPTION	30 PRICE PER UNIT / UNIT CODE	31 RRV UNIT	32 RRV RATE	33 TOTAL CHARGE	34 SPECIAL PAYMENT CHARGE
100	Room and Board			4	792.68	
			TOTALS		792.68	

001	PAGE	OF	CREATION DATE	792.68	792.68
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35 PAYER NAME Medicaid	36 HEALTH PLAN ID	37 POC EXT. #	38 POC EXT. #	39 POC EXT. #	40 POC EXT. #	41 POC EXT. #	42 POC EXT. #	43 POC EXT. #	44 POC EXT. #	45 POC EXT. #	46 POC EXT. #	47 POC EXT. #	48 POC EXT. #	49 POC EXT. #	50 POC EXT. #	51 POC EXT. #	52 POC EXT. #	53 POC EXT. #	54 POC EXT. #	55 POC EXT. #	56 POC EXT. #	57 POC EXT. #	58 POC EXT. #	59 POC EXT. #	60 POC EXT. #	61 POC EXT. #	62 POC EXT. #	63 POC EXT. #	64 POC EXT. #	65 POC EXT. #	66 POC EXT. #	67 POC EXT. #	68 POC EXT. #	69 POC EXT. #	70 POC EXT. #	71 POC EXT. #	72 POC EXT. #	73 POC EXT. #	74 POC EXT. #	75 POC EXT. #	76 POC EXT. #	77 POC EXT. #	78 POC EXT. #	79 POC EXT. #	80 POC EXT. #	81 POC EXT. #	82 POC EXT. #	83 POC EXT. #	84 POC EXT. #	85 POC EXT. #	86 POC EXT. #	87 POC EXT. #	88 POC EXT. #	89 POC EXT. #	90 POC EXT. #	91 POC EXT. #	92 POC EXT. #	93 POC EXT. #	94 POC EXT. #	95 POC EXT. #	96 POC EXT. #	97 POC EXT. #	98 POC EXT. #	99 POC EXT. #
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69 TREATMENT AUTHORIZATION CODES	70 DOCUMENT CONTROL NUMBER	71 EMPLOYER NAME
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72 7837	A	B	C	D	E	F	G	H	I
	J	K	L	M	N	O	P	Q	R

73 ADMIT CODE 7837	74 REFERRAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ICD-9 CODE	77 ICD-9 CODE	78 ICD-9 CODE	79 ICD-9 CODE	80 ICD-9 CODE	81 ICD-9 CODE	82 ICD-9 CODE	83 ICD-9 CODE	84 ICD-9 CODE	85 ICD-9 CODE	86 ICD-9 CODE	87 ICD-9 CODE	88 ICD-9 CODE	89 ICD-9 CODE	90 ICD-9 CODE	91 ICD-9 CODE	92 ICD-9 CODE	93 ICD-9 CODE	94 ICD-9 CODE	95 ICD-9 CODE	96 ICD-9 CODE	97 ICD-9 CODE	98 ICD-9 CODE	99 ICD-9 CODE
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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).

1 ABC Nursing Home Address City, State		2		3 Example 3a		4 X123400		5 653	
6 100108				7 17				8 30	

9 Doe, John		10		11		12		13	
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31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46

47	48	49	50	51	52	53	54	55	56
100	Room and Board						14		2,774.38

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57	58	59	60	61	62	63	64	65	66
Medicaid									8####

67	68	69	70	71	72	73	74	75
		AA###A#B						

76	77	78	79	80	81	82	83	84	85	86	87	88	89	90
7837														

91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110

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 with Home Health.
- 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. The day of discharge is not a covered day, so there are a total of 30 covered days and the last day in the Statement Covers Period is 12/30/08. Medicare pays 100 percent of the daily rate for days 1-20 (12/01/08 through 12/20/08). During days 21 through 31, Medicare pays all but the coinsurance amount (\$128.00 per day). **The facility would bill DMAP for the coinsurance amount from 12/21/08 through 12/30/08.**

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 the total amount you billed Medicare for the entire Statement Covers Period (12/21/08 through 12/30/08) - \$3,000.00.

FL 54 – Enter the total amount Medicare paid for the entire Statement Covers Period - \$1,720.00.

1 ABC Nursing Home Address City, State		Example 4		30 PAY. CONT. # X123400	4 TYPE OF BILL 211
5 REG. TRF. NO.			6 ISSUANCE BY PERIOD FROM 122108		7 COVERAGE PERIOD THROUGH 123008
NOVR					

8 PATIENT NAME a Doe, John	9 PATIENT ADDRESS b	10 ROOM NO. c	11 UNIT NO. d
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12 BIRTHDATE 13 SEX 14 DATE 15 ADMISSION 16 ICD-9-CM 17 ICD-9-CM 18 ICD-9-CM 19 ICD-9-CM 20 ICD-9-CM 21 ICD-9-CM 22 ICD-9-CM 23 ICD-9-CM 24 ICD-9-CM 25 ICD-9-CM 26 ICD-9-CM 27 ICD-9-CM 28 ICD-9-CM 29 ICD-9-CM 30 ICD-9-CM
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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 OCCURRENCE DATE 40 OCCURRENCE DATE 41 OCCURRENCE DATE 42 OCCURRENCE DATE 43 OCCURRENCE DATE 44 OCCURRENCE DATE 45 OCCURRENCE DATE 46 OCCURRENCE DATE 47 OCCURRENCE DATE 48 OCCURRENCE DATE 49 OCCURRENCE DATE 50 OCCURRENCE DATE
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51 CODE A2	52 VALUE CODES 1,280 00	53 CODE 70	54 VALUE CODES 112508	55 CODE 113008	56 VALUE CODES	57 VALUE CODES	58 VALUE CODES
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60 SERV. CD	61 DESCRIPTION	62 HCPCS ICD9 / ICD9-CM CODE	63 SERV. LEN	64 SERV. UNITS	65 TOTAL CHARGE	66 BASIC SERVICE CHARGE	67
022	Medicare Coinsurance			10	3,000 00		
					TOTALS	3,000 00	

001	PAGE	OF	CREATION DATE	TOTALS	3,000 00
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59 PRIOR NAME Medicare Medicaid	51 HEALTH PLAN ID	52 PRIOR PAYMENTS 1,720 00	53 EST AMOUNT DUE	54 UN. 8####	55 OTHER 8####	56 PROVID
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58 INSURER'S NAME	59 PLAN	60 INSURER'S UNIFORM ID Medicare Number AA###A#B	61 GROUP NAME	62 INSURANCE GROUP NO.
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63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
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66 7837	67 A	68 B	69 C	70 D	71 E	72 F	73 G	74 H	75 I
76 ADMIT 7837	77 INPATIENT 7837	78 OUTPATIENT 7837	79 OTHER 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 ICD-9-CM 7837
86 ICD-9-CM 7837	87 ICD-9-CM 7837	88 ICD-9-CM 7837	89 ICD-9-CM 7837	90 ICD-9-CM 7837	91 ICD-9-CM 7837	92 ICD-9-CM 7837	93 ICD-9-CM 7837	94 ICD-9-CM 7837	95 ICD-9-CM 7837

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.	1-800-527-5772
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