Nursing Facility
UB-04 Paper Billing Guide

Oregon Medicaid Nursing Facilities
November 2008

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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.

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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).

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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.

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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 Remarks 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.

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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.

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).

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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.

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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.

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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.

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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.

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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.

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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)

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3a PAT. CNTL #

b. MED. REC. #

4 TYPE OF BILL

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a

b

9 PATIENT ADDRESS a

b c d e

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

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

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39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

a
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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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23	PAGE ____ OF ____	CREATION DATE		TOTALS			

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

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL
LAST FIRST

77 OPERATING NPI QUAL
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80 REMARKS

81CC a b c d

78 OTHER NPI QUAL
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79 OTHER NPI QUAL
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UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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REQUIRED FIELD LOCATORS

The Field Locaters 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 **Appendix A** 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. • "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. 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.
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.).

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FL	FL Text	Billing Instructions
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.** **Always use Patient Status Code 30 on nursing facility claims.** If you use any other code, the last day in the Statement Covers Period will not be paid.
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 accident) or the from and through date of the occurrence.** Use MMDDYY format (123008). • **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. 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.
39-41	**Value Codes** Required for SNF claims	**Enter the appropriate value code(s) for Medicare Coinsurance and Deductible when Medicare is the primary payer.** • 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. 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

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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	**Enter the three (3)-digit code that most accurately describes the service provided.** See **Appendix C** for a list of applicable Revenue Center Codes. **Enter "001" in line 23 of this field** to indicate the claim's total charges (entered in FL 47).
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	**LEAVE THIS FIELD BLANK. If you enter the daily rate in this field, the claim will deny, suspend, or pay at the incorrect amount.**
46	Service Units	**Enter total days for each Revenue Center Code listed.** • 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. NOTE: Any time there is a Break in Service, you must submit a new UB-04. See Break in Service for more details.
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.

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FL	FL Text	Billing Instructions
50	**Payer Identification**	**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. • First line, 50a is the Primary Payer Name. • Second line, 50b is the Secondary Payer Name. • Third line, 50c is the Tertiary Payer Name. NOTE: • 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**	**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. • 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**	**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. • If there are other insurance numbers shown, such as Medicare, then the Medicaid identification number should appear last in the field. 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.
67	**Principal Diagnosis Code**	**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.

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FL	FL Text	Billing Instructions
		• 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**	**Enter up to four (4) additional ICD-9-CM codes, as appropriate.** You can enter additional diagnosis codes for conditions that: • 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 **Appendix D** for TPR explanation codes.

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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.

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APPENDIX B¶
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Field Locator 17 - Patient Status Codes

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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.

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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)

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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)

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APPENDIX D

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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

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APPENDIX E

Print Form | Reset Form | "Save As" to desk top

State of Oregon — Department of Human Services — Division of Medical Assistance Programs

Individual Adjustment Request

✓ Complete this form to request an adjustment.
✓ Please keep a copy and do not use red ink.

DMAP Use Only

(1) **Type of Adjustment:** ☐ Underpayment – Request additional payment
☐ Overpayment – Please deduct from subsequent payment

(2) **Attach the following:**
✓ Claim (corrected copy)
✓ Remittance Advice (copy)
✓ Financial planner (NH only)

(3) **Return nursing home adjustment requests to:**
DMAP – NH
PO Box 14954
Salem, OR 97309

Return all other adjustment requests to:
DMAP
PO Box 14952
Salem, OR 97309

Enter the following data from your Remittance Advice (RA):

(4) **Internal Control Number** (5) **RA Date**

(6) **Recipient Name** (7) **Recipient ID Number**

(8) **Provider Name** (9) **Provider Number**

(10) **NPI**

(11) Description of original error	(12) Line No.	(13) Service Date	(14) Wrong Information	(15) Right Information
☐ Place of Service				
☐ Procedure Code/NDC/Rev Code				
☐ Modifier				
☐ Quantity/Unit				
☐ Diagnosis				
☐ Prescribing/Performing Provider				
☐ Billed Amount/Total Billed				
☐ Medicare Payment				
☐ Other Insurance/Patient Liability				
☐ Co-Insurance				
☐ Other				

(16) **Remarks**

(17) **Provider's Signature** | **Phone #** | **Date**

DMAP 1036 – Page 1 (Rev 04/07)

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5. RA Date –
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7. Recipient I
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9. Provider N
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12. Line Numb
13. Service Da
14. Wrong Info
15. Right Infor
16. Remarks –
17. Requester

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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.

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ABC Nursing Home
Address
City, State

Example 1

3a PAT. CNTL #: X123400

4 TYPE OF BILL: 653

6 STATEMENT COVERS PERIOD FROM: 120108 THROUGH: 123108

8 PATIENT NAME: Doe, John

12 ADMISSION DATE: 110108 | 13 HR: 17 | 17 STAT: 30

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
100	Room and Board			31	6,143 27	
001	PAGE ___ OF ___	CREATION DATE		TOTALS	6,143 27	

50 PAYER NAME: Medicaid

56 NPI: ##########

57 OTHER PRV ID: 8######

60 INSURED'S UNIQUE ID: AA###A#B

67: 7837

69 ADMIT DX: 7837

78 OTHER NPI: ########## QUAL: ######

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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).

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ABC Nursing Home
Address
City, State

Example 2a

3a PAT. CNTL # X123400

4 TYPE OF BILL 651

6 STATEMENT COVERS PERIOD FROM 120108 THROUGH 120408

8 PATIENT NAME: Doe, John

12 ADMISSION DATE 120108

16 DHR 18

17 STAT 30

42 REV. CD.	43 DESCRIPTION	46 SERV. UNITS	47 TOTAL CHARGES
100	Room and Board	4	792 68
001	PAGE ___ OF ___ CREATION DATE	TOTALS	792 68

50 PAYER NAME: Medicaid

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

57 OTHER PRV ID 8#####

60 INSURED'S UNIQUE ID: AA###A#B

67 7837

69 ADMIT DX 7837

78 OTHER NPI ########## QUAL ######

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ABC Nursing Home
Address
City, State

Example 2b

3a PAT. CNTL # X123400
4 TYPE OF BILL 652

6 STATEMENT COVERS PERIOD FROM 120608 THROUGH 123108

8 PATIENT NAME: Doe, John

12 ADMISSION DATE 120608 | 13 HR 17 | 17 STAT 30

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
100	Room and Board			26	5,152 42	
001	PAGE ___ OF ___		CREATION DATE	TOTALS	5,152 42	

50 PAYER NAME: Medicaid

56 NPI ##########
57 OTHER PRV ID 8#####

60 INSURED'S UNIQUE ID: AA###A#B

67 7837

69 ADMIT DX 7837

78 OTHER NPI ########## QUAL ######

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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).

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ABC Nursing Home
Address
City, State

Example 3a

X123400

653

120108 121408

Doe, John

100108 17 30

Rev. Cd.	Description	Serv. Units	Total Charges
100	Room and Board	14	2,774 38
001	PAGE ___ OF ___ CREATION DATE	TOTALS	2,774 38

Medicaid

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8######

AA###A#B

7837

7837

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ABC Nursing Home
Address
City, State

Example 3b

3a PAT. CNTL # X123400

4 TYPE OF BILL 653

6 STATEMENT COVERS PERIOD FROM 121508 THROUGH 122108

8 PATIENT NAME: Doe, John

ADMISSION 12 DATE 100108 13 HR 17

17 STAT 30

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
100	Room and Board			7	1,942 08	
001	PAGE ___ OF ___	CREATION DATE		TOTALS	1,942 08	

50 PAYER NAME: Medicaid

56 NPI: ##########

57 OTHER PRV ID: 8######

60 INSURED'S UNIQUE ID: AA###A#B

67: 7837

69 ADMIT DX: 7837

78 OTHER NPI: ########## QUAL ######

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ABC Nursing Home
Address
City, State

Example 3c

X123400

653

STATEMENT COVERS PERIOD FROM	THROUGH
122208	123108

PATIENT NAME: Doe, John

ADMISSION DATE	HR	STAT
100108	17	30

REV. CD.	DESCRIPTION	HCPCS / RATE / HIPPS CODE	SERV. DATE	SERV. UNITS	TOTAL CHARGES
100	Room and Board			10	1,981 70
001	PAGE ___ OF ___	CREATION DATE		TOTALS	1,981 70

PAYER NAME: Medicaid

NPI: ##########

OTHER PRV ID: 8######

INSURED'S UNIQUE ID: AA###A#B

7837

ADMIT DX: 7837

OTHER: ########## ######

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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.**

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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.

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

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ABC Nursing Home
Address
City, State

Example 4

Field	Value
3a PAT. CNTL #	X123400
4 Type of Bill	211
6 Statement Covers Period From	122108
6 Statement Covers Period Through	123008
7	XOVR
8 Patient Name	Doe, John
12 Admission Date	120108
13 Admission Hr	16
16 DHR	17
17 STAT	30
35 Occurrence Span Code	70
35 Occurrence Span From	112508
35 Occurrence Span Through	113008
39 Value Codes Code	A2
39 Value Codes Amount	1,280 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
022	Medicare Coinsurance			10	3,000 00	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	3,000 00	

50 PAYER NAME	54 PRIOR PAYMENTS	56 NPI	57 OTHER PRV ID
Medicare	1,720 00	##########	8#####
Medicaid			

60 Insured's Unique ID: Medicare Number AA###A#B

67 Principal Diagnosis: 7837

69 Admit DX: 7837

78 Other NPI: ########## ######

APPENDIX F

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Contact Information

Contact	Phone
Automated Voice Response (AVR) To verify client eligibility, benefit packages, managed care coverage, primary care manager, or limited service information. • 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. • Available Monday through Friday - 8 a.m. to 5 p.m.	**1-800-336-6016**
DMAP Claims Unit For Individual Adjustment Requests Process. • 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. • 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. • Available Monday through Friday - 8 a.m. to 5 p.m.	**1-800-232-3020**

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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

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Appendix B – Patient Status Codes 20

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14	**Type of Admission or Service**	**Enter the one (1)-digit code to indicate type of service.** Use one of the following codes (see OAR 410-125-0401 for definitions): • **1** – Emergent • **2** – Urgent • **3** – Elective

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45	**Service Dates** Line 23	**Required. Enter Creation Date on line 23 (MMDDYYYY)**: Enter the date the bill was created or prepared for submission. Creation date on line 23 should be reported on all pages of the UB-04.

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76	**Attending Physician ID**	**Enter the ten (10)-digit NPI followed by the six (6) digit DHS provider number for the resident's attending physician (primary care physician).**

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01	Discharged to home or self care (routine discharge)
02	Discharged or transferred to an acute care hospital

03	Discharged or transferred to a SNF with Medicare certification in anticipation of covered skilled nursing facility care
04	Discharged or transferred to another intermediate care facility (ICF)
05	Discharged or transferred to another type of institution (not another acute care hospital)
06	Discharged or transferred to home under care of home health service organization
07	Left against medical advice
08	Discharged to home under care of Home Enteral/Parenteral Provider
20	Expired
30	Still a resident
50	Discharged or transferred to Hospice care
65	Discharged or transferred to a psychiatric hospital

NOTE: Nursing facilities are paid for the day a resident is admitted, but not the day they are discharged. The Patient Status Code is used during claims processing to determine whether or not to pay for the last date of service identified in FL 6 (Statement Covers Period) on the UB-04 claim form.

Nursing facilities can bill on a monthly basis for a resident who has not been discharged from the facility. If the resident is not discharged or transferred on the last day of the Statement Covers Period, you must use Patient Status code 30 in order to get paid for the last day of the Statement Covers Period. If you use any other Patient Status Code, the last day will be considered the day of discharge and you will not get paid for that day.

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Individual Adjustment Request Instructions

1. **Type of Adjustment –** Check the appropriate box.
4. **Internal Control Number (ICN) –** Enter the 13-digit ICN from the Remittance Advice (RA).
5. **RA Date –** Enter the date printed on the RA.
6. **Recipient Name –** Enter the recipient's name.
7. **Recipient ID Number –** Enter the recipient's ID number.
8. **Provider Name –** Enter your provider name.
9. **Provider Number –** Enter your six-digit DMAP provider number.
10. **National Provider Identifier (NPI) –** Enter your NPI number.
11. **Description of original error –** This column lists possible errors to be corrected.
12. **Line Number –** Enter the line number from the RA.
13. **Service Date –** Enter the date, or date range, of service for the service provided.
14. **Wrong Information –** Enter the incorrect information submitted on your original claim.
15. **Right Information –** Enter the correct information.
16. **Remarks –** Enter any other information you think necessary to accurately adjust your claim.
17. **Requester's Name –** Enter the provider or authorized representative's name.

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