

Medicare Part A billing: How to code the UB-04

Billing Medicare Part A for SNF services is a game of numbers, but, believe it or not, the digits of interest are not dollar amounts; they are codes.

SNF billers work with hundreds of diagnosis and procedure codes, known as ICD-9-CM, HCPCS, and CPT codes. Given the sheer volume of these codes, memorization is impossible. However, there are other codes billers should master, such as those on the UB-04 billing form.

Part A claims contain several types of codes that help tell the fiscal intermediary (FI) or Medicare administrative contractor (MAC) the story of a resident's treatment.

For claims to be accurate, certain data must be sent with each claim. The requirements for a given claim depend on the type of bill and the issues that occurred during that billing cycle.

In this report, we will discuss certain claim fields used on the UB-04 as they appear on the printed form, rather than how the information is submitted to the FI or MAC electronically, using the 837 format. To view the printed UB-04 form, see p. 4.

Type of bill: UB-04 field 4

The type of bill is a four-digit code in which the first digit, a leading zero, is dropped. The second digit identifies the type of facility submitting a claim. For SNFs, that digit will always be 2. The next digit classifies the type of care and will always be 1 for inpatient Part A claims. The last digit denotes the sequence of the claim and, for Part A claims, could be one of the following:

- 0—No-pay claim
- 1—Admit through discharge claim
- 2—Interim claim (first in the series)
- 3—Interim claim (continuing claim)
- 4—Interim claim (last in the series)
- 7—Replacement of a previous claim; adjustment claim
- 8—Cancellation of a previous claim

Statement covers period: UB-04 field 6

The statement period includes the beginning and ending dates for the bill period, usually the calendar month. The through date can be confusing. When the resident leaves the facility, the day of discharge is used.

The day of discharge is not paid by Medicare and is the first noncovered day. However, when the resident is taken off Medicare and remains in the facility, the last covered day is entered as the through date.

Patient status: UB-04 field 17

"Ultimately, the type of bill drives the patient status," says **Mary Marshall, PhD**, president of Management & Planning Services, Inc., in Fernandina Beach, FL. "SNF bill-

ers must ensure that the patient status

"Ultimately, the type of bill drives the patient status."

—*Mary Marshall, PhD*

code is appropriate for the type of bill. Otherwise, the claim will be rejected."

The most commonly used patient status code for SNFs is 30, indicating that the resident still remains in the facility. This code must appear on bill types 212 and 213.

Patient status for bill types 211 and 214 frequently include one of the following:

- 01—Discharged to home or self-care
- 02—Discharged/transferred to a short-term general hospital for inpatient care
- 20—Expired

There are also several additional codes that can be used (e.g., 03, 04, 06, and 07).

Condition codes: UB-04 fields 18–28

Condition codes identify provisions and certain circumstances, such as billing for denial or medical

> *continued on p. 2*

appropriateness, with a particular bill. Some commonly used condition codes and the conditions they indicate are:

- 20**—Beneficiary requested billing. Used to identify the claim as a beneficiary and/or responsible party claim (e.g, a demand bill).
- 21**—Billing for denial notice. Used to trigger a denial notice when services drop to a noncovered level or are excluded by Medicare in order to bill another payer.
- 56**—Medical appropriateness. Used to override the edit that denies a claim because the service dates are more than 30 days past the qualifying hospital stay and the delayed services were predictable at the time of admission.
- 57**—SNF readmission. Must be used in conjunction with occurrence span code 78 to indicate prior SNF days when admission is within 30 days of discharge from Medicare but more than 30 days from the qualifying hospital stay.
- 58**—Identifies a claim submitted for a beneficiary who is covered by a Medicare Advantage plan that was terminated after he or she was admitted to the SNF. This will bypass the edit for the three-day qualifying hospital stay.

When the Quality Indicator Organization (QIO) performs an expedited review, the biller must select the appropriate QIO indicator code (C3, C4, C7) to report the QIO decision.

Occurrence codes: UB-04 fields 31–34

Occurrence codes indicate specific events that are connected with the claim and could affect processing and payment, such as the last day of skilled care.

Most occurrence codes required for SNFs are used for Medicare Part B claims. However, occurrence code 22, which indicates the last day of skilled care, is used on Part A claims when a resident was discharged from Medicare but remains in the facility under a non-Medicare level of care.

“All occurrence codes have a date, and occurrence code 22 needs to be accompanied by the last covered day,” Marshall says. This date correlates to the through date in the statement covers period.

Occurrence span code and dates: UB-04 fields 35 and 36

Occurrence span codes indicate events that occurred over time and affect payment, such as a qualifying three-day hospital stay. Two common occurrence span codes used on Part A SNF claims are:

- 70**—Qualifying three-day hospital stay dates. If the resident has more than one hospital stay, use the most current hospital stay dates. Be sure there are three days, not including the day of discharge.
- 78**—SNF prior-stay dates. Use this code to connect the qualifying three-day hospital stay dates to a previous SNF stay.

The 78 occurrence span code and dates are commonly used when a resident is cut from Part A services because of a change in the required level of care but requires skilled care within 30 days because of a decline in condition.

As long as the next skilled stay is within the 30-day window, the Medicare coverage can continue without another three-day qualifying hospital stay. This needs to be used in conjunction with condition code 57.

The 78 occurrence span code and dates are also used when a resident is discharged from one SNF during a Part A stay and readmitted to another SNF without a hospital stay in between. As long as the transfer is made within 30 days of the last covered Part A day, the Medicare coverage can continue without another three-day qualifying hospital stay.

Value codes and amounts: UB-04 fields 39–41

A few common value codes used on Part A SNF claims are:

- 80**—Covered days. Report the number of days covered by Medicare Part A.

81—Noncovered days. Report the number of days not covered by Medicare Part A. Be sure to report the corresponding revenue for noncovered charges in UB-04 field 48.

82—Coinsurance days. Report the number of covered days that are subject to coinsurance. For SNF claims, this would be days 21–100.

Revenue codes: UB-04 field 42

Revenue codes are used to identify the specific type of service a resident receives. There are revenue codes for everything from the resident’s room and board to ambulance transportation.

For a Medicare Part A stay, the revenue code 0022 must be sequenced first on the UB-04 to indicate payment under SNF PPS. Other commonly used revenue codes are listed in the table below.

Common Part A revenue descriptions	Revenue code
Room and board (private)	011X
Room and board (semiprivate room, two beds)	012X
Room and board (semiprivate room, three and four beds)	013X
Room and board (ward)	015X
Leave of absence (noncovered day)	018X
Pharmacy	025X
IV therapy	026X
Medical supplies	027X
Laboratory	030X
Radiology (diagnostic)	032X
Respiratory services	041X
Physical therapy	042X
Occupational therapy	043X
Speech-language pathology	044X
Audiology	047X
Ambulance services	054X
Complex medical equipment (ancillary)	0947

HCPCS/rate: UB-04 field 44

This field uses the HIPPS code to identify the type of assessment that was prepared. The HIPPS code combines the three-digit resource utilization group (RUG) score with a two-digit assessment indicator and links to the predetermined payment rate.

A separate line should be used for each assessment billed on the claim, and each line should contain revenue code 0022.

This field also identifies the accommodation rate, which is the rate charged for the room being occupied by the Part A resident.

It will correspond with the revenue code for room and board of 12X, 13X, or 14X.

Service dates: UB-04 field 45

This field is used to identify the MDS assessment reference date for the corresponding HIPPS code. A separate line should be used for each assessment that was prepared for the claim.

Service units: UB-04 field 46

This field is used to report the number of days that correspond to the appropriate HIPPS code. A separate line should be used for each assessment that was prepared for the claim.

“Errors can be made in billing for more days than what is allowed by the RUG,” Marshall says. “For example, a five-day assessment generates a RUG that will pay for 14 days. If you put 15 days on the claim, it will not go through.

“Some FIs or MACs have actually held such claims and checked which assessment was done using the state database for the MDS. The HIPPS code that is included on a Part A bill indicates what MDS assessment was done and, therefore, how many days should be billed,” she says.

This field is also used to provide information on billed services (e.g., covered days). Covered days should be on the same line as the accommodation rate.

For ancillary services, this field is used to report treatments or tests, depending on the service reported.

NPI: UB-04 field 56

As of May 23, 2007, all providers are required to submit health insurance claims using the National Provider Identifier (NPI).

> *continued on p. 5*

UB-04

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b	b	c	d
10 BIRTHDATE	11 SEX	12 DATE	13 HR
14 TYPE	15 SRC	16 DHR	17 STAT
18	19	20	21
22	23	24	25
26	27	28	29 ACCT STATE
30	31 OCCURRENCE DATE	32 CODE	33 OCCURRENCE DATE
34 CODE	35 OCCURRENCE DATE	36 CODE	37 OCCURRENCE DATE
38	39 CODE	40 VALUE CODES AMOUNT	41 CODE
a	b	c	d
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE
46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
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	57 OTHER PRV ID
58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
66 DX	67	A	B
C	D	E	F
G	H	I	J
K	L	M	N
O	P	Q	68
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI
73	74 PRINCIPAL PROCEDURE CODE	75	76 ATTENDING NPI
77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 REMARKS
81CC a	b	c	d

UB-04 CMS-1450

APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee LIC9213257

Source: CMS.

Diagnosis codes: UB-04 fields 67, 67a–67q

The provider should include the principal diagnosis in field 67. The principal diagnosis identifies the condition chiefly responsible for the patient's admission or continued stay in the nursing facility, according to CMS' *ICD-9-CM Official Guidelines for Coding and Reporting*, 2008 version. Acute codes for cerebrovascular accidents, myocardial infarctions, and fractures should not be used. The SNF should always use the late-effect codes even if the patient was only in the hospital for a short period.

Additional or secondary diagnoses codes should be included on the current bill in fields 67a–67q to represent the clinical status of the beneficiary and further support the need for a nursing home stay.

However, Medicare does not look at the i–q fields. Although there are currently no guidelines on sequencing secondary codes, these additional codes should include other comorbidities that have an effect on the beneficiary's complexity, clinical conditions that arose in the SNF, and diagnoses that may affect the resident's treatment or length of stay.

V codes are for use in any healthcare setting. These codes deal with encounters for circumstances other than a disease or injury and require a corresponding procedure and/or treatment code to support the necessity of the encounter.

V codes may be used as a principal or secondary diagnosis, depending on the circumstances of the encounter. Some V codes are reserved for first-listed, whereas others

are reserved for secondary codes only. CMS' *ICD-9-CM Official Guidelines for Coding and Reporting* contains detailed instructions for using V codes.

Long-term care billers commonly use V codes for the delivery of aftercare to cover situations in which the patient has received initial treatment for a disease or injury and continued care during the healing or recovery phase. Keywords that might trigger the use of V codes include absence, admission for, aftercare, attention to, history of, replacement, resistance, and status post.

Below are some other points to keep in mind about aftercare codes:

- ▶ The aftercare V code should not be used if treatment is directed at a current acute disease or injury. Use the appropriate diagnosis code in these situations.
- ▶ Aftercare codes are generally first-listed to explain the specific reason for the encounter (e.g., V58.49, Other specified aftercare following surgery; V54.xx, Other orthopedic aftercare; V57.xx, Care involving the use of rehabilitation procedures).
- ▶ When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from Category V57 as the principal/first-listed diagnosis.

Editor's note: Parts of this special report were taken from HCPro's How to Bill Medicare for Skilled Nursing Facilities, Second Edition, by Lee Heinbaugh, and HCPro's Long-Term Care Pocket Guide to Part A Billing. For more information or to order, call 800/650-6787 or visit www.hcmarketplace.com.

This special report is published by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. • Copyright © 2009 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For renewal or subscription information, call customer service at 800/650-6787, fax 800/639-8511, or e-mail customerservice@hcpro.com. • Opinions expressed are not necessarily those of the editors. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. HCPro, Inc., is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.