Agenda

- Objectives
- Types of UB-04 claims
- Providers using UB-04 claim form
- UB-04 required fields on paper claims
- Enhanced code auditing
- Upcoming changes for ICD-10
- Recent changes
- Covered services, reimbursement, and billing
- Most common denials
- Questions
Objectives

– Provide a comprehensive explanation of the following:
  • Which provider types use the UB-04 institutional claim form
  • The various ways the claim can be filed
  • Detailed instructions for how the claim form is completed

– Review specific billing intricacies for different provider types

– Explain common denial reasons
Types of UB-04 Claims

- **837I – Electronic Transaction**
  - Companion guide available on indianamedicaid.com
- **Web interChange**
- **Paper Claim**
- **Adjustment Request** (for a previously paid claim)
Providers Using the UB-04 Form

IHCP Provider Manual, Chapter 8, Section 2

- Ambulatory surgical centers (ASCs)
- End-stage renal disease (ESRD) clinics
- Home health agencies (HHAs)
- Hospices
- Hospitals
- Long-term care (LTC) facilities
- Rehabilitation hospital facilities
Require
Fields on UB-04 Institutional Paper Claims
Required Fields on Paper UB-04

<table>
<thead>
<tr>
<th>Field</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER NAME</td>
<td>Provider Name</td>
</tr>
<tr>
<td>CITY</td>
<td>City</td>
</tr>
<tr>
<td>STATE</td>
<td>State</td>
</tr>
<tr>
<td>ZIP+4</td>
<td>ZIP Code</td>
</tr>
<tr>
<td>NAME</td>
<td>Patient Name</td>
</tr>
<tr>
<td>SEX</td>
<td>Patient Sex</td>
</tr>
<tr>
<td>DATE</td>
<td>Admission Date</td>
</tr>
<tr>
<td>HR</td>
<td>Admission HR</td>
</tr>
<tr>
<td>STAT</td>
<td>Admission STAT</td>
</tr>
<tr>
<td>CODE</td>
<td>Condition Code</td>
</tr>
<tr>
<td>OCCURRENCE DATE</td>
<td>Occurrence Date</td>
</tr>
<tr>
<td>VALUE CODES AMOUNT</td>
<td>A1 750.00</td>
</tr>
<tr>
<td>REV. CD</td>
<td>Description</td>
</tr>
<tr>
<td>ROOM BOARD SEMI</td>
<td>0120 200.00</td>
</tr>
<tr>
<td>CTSCAN</td>
<td>0351 800.00</td>
</tr>
</tbody>
</table>
**Required Fields on Paper UB-04**

<table>
<thead>
<tr>
<th>Required Fields</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICARE</strong></td>
<td>BCBS</td>
</tr>
<tr>
<td><strong>BCBS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td></td>
</tr>
<tr>
<td><strong>INSURED’S NAME</strong></td>
<td>MEMBER MEDICAID R ID</td>
</tr>
<tr>
<td><strong>TREATMENT AUTHORIZATION CODES</strong></td>
<td>25000</td>
</tr>
<tr>
<td><strong>PATIENT REASON DX</strong></td>
<td>Y 31401 Y</td>
</tr>
<tr>
<td><strong>PRINCIPAL PROCEDURE CODE</strong></td>
<td>a</td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td>b</td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE CODE</strong></td>
<td>c</td>
</tr>
<tr>
<td><strong>PRINCIPAL PROCEDURE DATE</strong></td>
<td>d</td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE DATE</strong></td>
<td>e</td>
</tr>
<tr>
<td><strong>OTHER PROCEDURE DATE</strong></td>
<td>f</td>
</tr>
<tr>
<td><strong>REMARKS</strong></td>
<td>a</td>
</tr>
<tr>
<td></td>
<td>b</td>
</tr>
<tr>
<td></td>
<td>c</td>
</tr>
<tr>
<td></td>
<td>d</td>
</tr>
</tbody>
</table>
Required Fields on Paper UB-04

- Field 1: BLANK
  - Billing provider service location name, address, and ZIP Code +4

- Field 4: TYPE OF BILL
  - Three-digit code indicating specific type of bill
    - First position – Type of Facility
    - Second position – Bill Classification
    - Third position – Frequency
    - EXAMPLE: TOB 111 – Hospital, Inpatient, Admit thru Discharge Claim

- Field 6: STATEMENT COVERS PERIOD, FROM/THROUGH
  - Beginning and ending service dates in MMDDYY format

- Field 8b: PATIENT NAME
  - Last name, first name, middle initial

- Field 12: ADMISSION DATE
  - Date of admission for inpatient care
  - Required for inpatient and long-term care (LTC)
Required Fields on Paper UB-04

- **Field 13: ADMISSION HOUR**
  - Hour during which patient was admitted for inpatient care
  - Required for inpatient
    - Example: Code 00 – 12 a.m. to 12:59 a.m.

- **Field 14: ADMISSION TYPE**
  - Indicates priority of admission
  - Required for inpatient and LTC
    - 1 Emergency
    - 2 Urgent
    - 3 Elective
    - 4 Newborn
    - 5 Trauma Center
    - 9 Unspecified
Required Fields on Paper UB-04

- Field 17: STATUS
  - Indicates the discharge status as of ending service date
  - Required for inpatient and LTC
  - *IHCP Provider Manual, Chapter 8, Section 2* has complete list
  - Examples:
    - 01 Discharged to home or self-care, routine discharge
    - 03 Discharged or transferred to skilled nursing facility (SNF)
    - 20 Expired
    - 30 Still a patient
    - 51 Discharged to hospice – medical facility
Required Fields on Paper UB-04

- Fields 18-24: CONDITION CODES
  - Identifies conditions relating to the bill that may affect processing
  - Required, if applicable
  - Examples:
    - 02  Condition is employment-related
    - 40  Same-day transfer

- Fields 31a-34b: OCCURRENCE CODE and DATE
  - Code and associated date identify significant events relating to the bill that may affect processing
  - Required if applicable
  - Maximum of eight codes allowed
  - Examples:
    - 51  Date of discharge
    - 53  Therapy evaluation (shows Home Health Agency billing for initial therapy evaluations)
    - 61  Home health overhead amount – one per day
Required Fields on Paper UB-04

- Field 39a-41d: VALUE CODES
  - Use these fields to indicate Medicare Remittance Notice (MRN) information
  - Use for Medicare Crossover and Medicare Replacement Plans
    - A1  Medicare deductible amount
    - A2  Medicare coinsurance amount
    - 06  Medicare blood deductible
  - Also use Value Code 80 to indicate the number of IHCP covered days

- Field 42: REV. CODE
  - This field is for the three-digit revenue code that identifies the specific accommodation, ancillary service, or billing calculation
  - *IHCP Provider Manual, Chapter 8, Table 8.5 includes a detailed list*
Required Fields on Paper UB-04

- Field 43: DESCRIPTION
  - Report National Drug Code (NDC) information, if applicable
    - NDC qualifier N4
    - NDC 11-digit numeric code in "5-4-2" format
    - NDC unit of measure qualifier, such as ML for milliliter
    - NDC quantity

<table>
<thead>
<tr>
<th>42 REV. CO.</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS / RATE / HIPPS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGES</th>
<th>48 NON-COVERED CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0636</td>
<td>N450242006001ML0.4</td>
<td>J9035</td>
<td>DATE 1</td>
<td>78.95</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Required Fields on Paper UB-04

– Field 44: HCPCS/RATE/HIPPS CODE

• Use the Healthcare Common Procedure Coding System (HCPCS) code applicable to the service provided

• Required for home health, outpatient, and ASC services

• Provide up to four modifiers, if applicable
Required Fields on Paper UB-04

– Field 45: SERV. DATE
  • Indicate the date the service was rendered
  • Required for home health, hospice, outpatient, and ASC services
  • Creation Date in field 45, line 23 is the date the bill was submitted (required)

– Field 46: SERV. UNITS
  • Provide the number of units corresponding to the revenue code or procedure code
  • Seven digits allowed, must be whole numbers

– Field 47: TOTAL CHARGES
  • Enter the total charge pertaining to the related revenue code for the statement covers period
  • Enter the sum of all charges on line 23 (sum should only be entered on last page of claim)
Required Fields on Paper UB-04

- Fields 50 through 65, lines A through C
  - Line A – Medicare information, including Medicare replacement plans and Medicare supplements
  - Line B – All other insurance carrier information only
  - Line C – Indiana Medicaid information only

- Field 50: PAYER NAME
  - Line A – Enter Medicare carrier's name
  - Line B – Name of other insurance company
    - If Medicare exhaust claim, indicate “EXHAUST”
  - Line C – Enter applicable IHCP Medicaid program, such as Traditional Medicaid or 590 Program

- Field 54: PRIOR PAYMENTS
  - Line A – Enter payments from Medicare
  - Line B – Enter payments from all other insurance companies
Required Fields on Paper UB-04

- Field 55: EST. AMOUNT DUE
  - Line A – Should be blank
  - Line B – Should be blank
  - Line C – Total charges from field 47, line 23; minus prior payments from block 54 A and/or 54 B

- Field 56: NPI
  - Indicate the billing provider's 10-digit National Provider Identifier (NPI)
  - If a one-to-one match cannot be established between the NPI and the Legacy Provider Identifier (LPI), enter B3 qualifier and taxonomy code in field 81cc (a)
  - Do not use the LPI in field 57

- Field 58 A – C: INSURED'S NAME
  - Enter insured's last name, first name, and middle initial
Required Fields on Paper UB-04

- Fields 60 A-C: INSURED'S UNIQUE ID
  - Line A – Medicare identification number
  - Line B – Insurance identification number
  - Line C – Member's Medicaid identification number (RID #)

- Field 61 A-C: GROUP NAME
  - Enter name of insurance group or plan

- Field 62 A-C: INSURANCE GROUP NO.
  - Enter the identification number, control number, or code assigned by the carrier
Required Fields on Paper UB-04

- **Field 67: PRIN.DIAG. CD.**
  - Enter the ICD-9-CM code describing the principal diagnosis

- **Field 67 A-Q: OTHER DIAGNOSIS CODES**
  - Provide the ICD-9-CM codes for additional conditions that coexist at the time of admission or develop subsequently
  - Hospital acquired conditions-present on admission (POA) indicators
  - Required for all inpatient stays with a from date of service on or after July 1, 2012
Required Fields on Paper UB-04

- **Field 69: ADM. DIAG. CD.**
  - Code provided at time of admission as stated by physician
  - Required for inpatient and LTC

- **Field 72: ECI (E-CODE)**
  - Use the appropriate "external cause of injury" code at time of admission as stated by physician (required if applicable)

- **Field 74: PRINCIPAL PROCEDURE CODE/DATE**
  - Use the ICD-9-CM procedure code that identifies the principal procedure performed and the date the procedure was performed
  - Required for inpatient procedures

- **Field 74 a-e: OTHER PROCEDURE CODE/DATE**
  - Use ICD-9-CM procedure code for other significant procedures and the date performed
  - Required when appropriate for inpatient procedures
Required Fields on Paper UB-04

- Field 74 a-e: OTHER PROCEDURE CODE/DATE
  - Use ICD-9-CM procedure code for other significant procedures and the date performed
  - Required when appropriate for inpatient procedures

- Field 76: ATTENDING PHYS. ID
  - Enter the attending physician’s NPI
  - Required for inpatient, outpatient, ASC, and LTC

- Field 77: OPERATING PHYS. ID
  - Enter the operating physician’s NPI
  - Required for inpatient
Let’s Play **TRUE or FALSE**

- The best way to file a UB-04 is on paper?
  - FALSE

- The member’s Medicaid RID# goes in field 60 C?
  - TRUE

- A status code of 30 in field 17 indicates the patient has been discharged?
  - FALSE

- Value code A2 would be used to indicate the Medicare coinsurance on a Medicare replacement plan?
  - TRUE

- The estimated amount due in field 55C should be the total charges in field 47, line 23, minus the prior payments in field 54 A or B?
  - TRUE

- A signature is required on a paper UB-04?
  - FALSE
Enhanced Code Auditing

Why did the IHCP implement the enhanced code auditing?

- The Indiana Health Coverage Programs (IHCP) implemented enhanced code auditing in the claims processing to support the Office of Medicaid Policy and Planning’s (OMPP’s) effort to promote and enforce correct coding efforts for more appropriate and accurate program reimbursement.
Enhanced Code Auditing

What supporting information is used for the new code auditing rules?

- Code auditing rules that have been implemented represent correct coding methodologies and other coding methods based upon general guidance from:
  - Centers for Medicare & Medicaid Services (CMS)
  - American Medical Association (AMA)
  - Specialty society guidance
  - Industry standard coding
  - Prevailing clinical practice
Enhanced Code Auditing

Multiple component billing

- What is it?
  - Identifies claims containing two or more procedure codes used to report individual components of a service when a single, more comprehensive procedure code exists that more accurately represents the service performed
  - Individual unbundled procedures will be denied
Enhanced Code Auditing
Multiple component billing – Laboratory  BT201103

– Identifies when individual components of a bundled service are billed separately rather than using the comprehensive CPT code of the laboratory panel

– Unbundled code line items will be denied:
  • Edit 4186
    ➢ Service denied. This is a component of a more comprehensive service. This service is reimbursed under a distinct comprehensive code.
    ➢ Utilize Clear Claim Connection tool on the Web interChange.
  • Healthcare services should be reported with the procedure code that most comprehensively describes the services performed
## Enhanced Code Auditing

### Multiple component billing – Example of lab panel rebundling

<table>
<thead>
<tr>
<th>Line Number</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Description</th>
<th>Billed Amount</th>
<th>Component Rebundling EOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>4/1/2012</td>
<td>30X</td>
<td>82040</td>
<td>Albumin; serum, plasma or whole blood</td>
<td>$100</td>
<td>denied with EOB 4186</td>
</tr>
<tr>
<td>02</td>
<td>4/1/2012</td>
<td>30X</td>
<td>82247</td>
<td>Bilirubin; total</td>
<td>$100</td>
<td>denied with EOB 4186</td>
</tr>
<tr>
<td>03</td>
<td>4/1/2012</td>
<td>30X</td>
<td>82248</td>
<td>Bilirubin; total direct</td>
<td>$100</td>
<td>denied with EOB 4186</td>
</tr>
<tr>
<td>04</td>
<td>4/1/2012</td>
<td>30X</td>
<td>84075</td>
<td>Phosphatase, alkaline</td>
<td>$100</td>
<td>denied with EOB 4186</td>
</tr>
<tr>
<td>05</td>
<td>4/1/2012</td>
<td>30X</td>
<td>84155</td>
<td>Protein, total, except by refractometry; serum, plasma or whole blood</td>
<td>$100</td>
<td>denied with EOB 4186</td>
</tr>
<tr>
<td>06</td>
<td>4/1/2012</td>
<td>30X</td>
<td>84450</td>
<td>Transferase; aspartate amino (AST) (SGOT)</td>
<td>$100</td>
<td>denied with EOB 4186</td>
</tr>
<tr>
<td>07</td>
<td>4/1/2012</td>
<td>30X</td>
<td>84460</td>
<td>Transferase; alanine amino (ALT) (SGPT)</td>
<td>$100</td>
<td>denied with EOB 4186</td>
</tr>
</tbody>
</table>
Enhanced Code Auditing

Auditing methodologies – BT201134

- UB-04 claims that are billed with multiple units of the same laboratory code on the same date of service
  - Repeat labs to validate, rerun, or confirm results are not an appropriate use of modifier 91

- Repeat labs on the same date of service for the same member are reportable and reimbursable when modifier 91 is appended to the claim

- Code auditing of bilateral services billed with a unit of service quantity greater than one
  - Edit 4195 - Procedures billed with modifier 50 indicate a bilateral procedure and a line quantity greater than one is not allowed. Specific bilateral procedures (conditionally bilateral and independently bilateral) billed with a quantity greater than one are denied.
Enhanced Code Auditing

Billing reminders – Use of modifiers

- Modifiers may be appended to Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT®) codes only when clinical circumstances justify them.

- A modifier should not be appended to an HCPCS/CPT code solely to bypass Component Rebundling auditing.
  - The use of modifiers affects the accuracy of claims billing and reimbursement, and Component Rebundling auditing.
  - Same procedures, performed during the same session:
    - Roll all the units to a single line, unless otherwise specified in medical policy.
Hospital Assessment Fee (HAF)

General information

- See bulletin BT201217
- The change impacts the following claim types for eligible hospitals:
  - Inpatient
  - Outpatient
  - Crossover
- The RA provides information about claims processing and financial activity
HAF Calculation

General information

- Reimbursement methodology is applied to the inpatient diagnosis-related group (DRG) base rate, inpatient level-of-care (LOC) per-diem rates, and outpatient rates.

- The HAF calculation does not include outliers, capital costs, medical education reimbursement, or the previous 5% reduction.

- The increased HAF reimbursement will not apply until the member has met his or her spend-down liability.

- The HAF Fee Schedule calculation can be found on indianamedicaid.com.
New HAF EOBs and ARC

- Inpatient and inpatient crossover claims paid using the HAF reimbursement methodology will set a new header edit 9032 – *Hospital Assessment Fee*

- Outpatient and outpatient crossover claims paid using the HAF reimbursement methodology will set a new detail edit 9033 – *Hospital Assessment Fee*
  
  • These edits are informational only and will not cause claims to deny

- The increased adjustment payment amount due to HAF will appear with adjustment reason code (ARC) 169 – *Alternate Benefit Provided*

**Note:** Explanation of benefits (EOB) edits 9032 and 9033 will not appear on the 835 transaction
3M™ APR-DRG for ICD-10

- The IHCP has selected the 3M All Patient Refined (APR) Diagnosis-Related Group (DRG) as the grouper for the ICD-10
- The IHCP will move forward with this APR-DRG methodology on the ICD-10 effective date of October 1, 2013
- This new grouper will be used for ICD-10 but will not replace the AP version 18 now used for dates of service before the ICD-10 effective date
- The IHCP will not support AP version 18 after the implementation of ICD-10
- Watch for up-to-date information about the new APR-DRG in future IHCP communications
Patient Status and Admission Type

– See banner page BR201226

– Effective for date of receipt June 27, 2012, Patient Status and Admission Type fields are required for all Web interChange institutional claim submissions

– If an institutional claim is submitted using Web interChange without a patient status, an error message appears stating, “Patient Status is required”

– If an institutional claim is submitted using Web interChange without an admission type, an error message appears stating, “Admission Type is invalid”
Medicare Payer ID

- See banner page BR201230

- Part A – Payer ID 08101 – Wisconsin Physician Service (WPS)
  - Payer ID 08101 replaced Payer ID 00130

- Part B – Payer ID 08102 – Wisconsin Physician Service (WPS)
  - Payer ID 08102 replaced Payer ID 00630

- Wisconsin Physician Service (WPS) replaced National Government Services (NGS)
Present On Admission (POA) Indicator

- See bulletin BT201209

- POA reporting is required for inpatient claims with a “From” date of service on or after July 1, 2012

- POA indicator reporting includes all Medicaid-enrolled hospitals
  - For a list of exempt diagnosis codes, see the ICD-9-CM Official Guidelines for Coding and Reporting on the CMS website at cms.gov
  - A complete list of the Hospital Acquired Conditions (HAC) categories and their corresponding complication or comorbidity (CC) or major complication or comorbidity (MCC) codes can be found in BT201219
  - POA indicators and definitions for nonexempt HAC diagnosis codes can be found in BT201219
Present On Admission (POA) Indicator

- See bulletin BT201209
- Common POA explanation of benefits (EOBs) codes
- 4250 - The Principal Diagnosis POA Indicator is Missing or Invalid
  - This edit will post to the claim when the provider has omitted the POA or submitted an invalid POA indicator
- 4251-4275 - The Secondary Diagnosis POA is Missing or Invalid
  - These edits will post to the claim for secondary diagnoses (1-24) if the POA is missing or invalid. The specific diagnosis field will be identified in the EOB message.
  - Example:
    - 4251 – First Secondary Diagnosis POA Missing or Invalid
    - 4252 – Second Secondary Diagnosis POA Missing or Invalid
Explain
Services, Reimbursement, and Billing
Inpatient Services

Covered services

- Inpatient services, such as acute care, mental health, and rehabilitation care, are covered when the services are provided or prescribed by a physician and are medically necessary for the diagnosis and treatment of the member’s condition
Hospital Inpatient Services

Reimbursement methodologies

- The IHCP reimburses hospital inpatient claims on a Level of Care (LOC) / Diagnosis-Related Group (DRG) hybrid reimbursement system
  - DRG system that reimburses a per-case rate according to diagnoses, procedures, age, gender, and discharge status
  - LOC system that reimburses psychiatric, burn, and rehabilitation cases on a per diem basis
- Additional components for capital, medical education, and outlier payments, if applicable
Inpatient Stays Less than 24 Hours

- Inpatient stays less than 24 hours should be billed as an outpatient service
  • Exceptions
    ➢ DRG 637 Neonate, died within one day of birth, born here
    ➢ DRG 638 Neonate, died within one day of birth, not born here

- Inpatient claims for stays less than 24 hours will deny for edit 0501 – Discharge within 24 hours of inpatient admission
Outpatient Services within Three Days of an Inpatient Stay

– Outpatient services that occur within three days preceding an inpatient admission to the same facility, for the same or related diagnosis, are considered part of the corresponding inpatient admission

– "Same" or "related" refers to the principal diagnosis and is based on the first three digits of the ICD-9 code

– If the outpatient claim is paid before the inpatient claim, the inpatient claim will deny for edit 6515 – Inpatient admit date within 3 days of DOS of paid outpatient claim
  • Void outpatient claim and rebill inpatient claim including outpatient charges

– If the inpatient claim is paid before the outpatient claim, the outpatient claim will deny for edit 6516 – Outpatient services rendered within 3 days prior to admit date of paid inpatient claim
  • Replace the inpatient claim, including the outpatient charges
Inpatient Services

Readmissions

– A readmission is defined as a hospital admission within three days following a previous hospital admission and discharge, from the same hospital, for the same or related condition

– "Same" or "related" is based on the principal diagnosis, and is based on the first three digits of the ICD-9 code

– Providers should bill one inpatient claim when the patient is readmitted within three days of a previous inpatient discharge
Inpatient Claims
Readmission – Billing example

- Patient is admitted May 19, 2012, and discharged May 23, 2012
- Patient is readmitted May 25, 2012, and discharged May 28, 2012
- The hospital bills with STATEMENT COVERS PERIOD FROM 5/19/12 THROUGH 5/28/12
- Covered days are nine
  - May 19-27
- Room and board days are seven
  - May 19, 20, 21, 22, 25, 26, 27
Inpatient Claims

Transfers

- Receiving hospital is reimbursed on DRG or LOC methodology
- Transferring hospital is reimbursed a DRG prorated daily rate for each day
  - Daily rate is DRG rate divided by ALOS (average length of stay)
- The appropriate discharge status must be placed in field 17
- Transferring hospitals do not receive separate DRG reimbursement when the patient returns from the transferee hospital for the same condition
  - Original admission and subsequent return must be combined on one claim
- DRGs 639 and 640 (Neonates transferred < 5 days old) exempted
- Claims for patients transferred within 24 hours of admission are billed as outpatient
Inpatient Admissions

Prior authorization

- Prior authorization (PA) is required for all urgent and non-emergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions
- This applies to medical and surgical inpatient admissions
- Emergency admissions, trauma, routine vaginal deliveries, C-section deliveries, and newborn stays do not require PA
- Observation does not require PA
- Inpatient admissions for burn care do not require PA, if admit type is 01 (emergency) or 05 (trauma), effective May 5, 2011
- This applies to Traditional Medicaid, including Care Select
  - Applies to the dually eligible if Medicare does not cover the stay
Outpatient Claims

Coverage

- Outpatient services are those provided to members who are not registered as inpatients at a hospital
- Outpatient services are covered when they are provided or prescribed by a physician and when the services are medically necessary for the diagnosis and treatment of the member’s condition
- Four categories of service within the outpatient hospital prospective payment system:
  - Outpatient surgeries
  - Treatment room visits
  - Stand-alone services
  - Add-on services
Outpatient Claims

Outpatient surgeries

- Outpatient surgeries are reimbursed at an all-inclusive flat rate (ASC rate) that covers all related procedures

- Surgical revenue codes
  - 36X Operating room services
  - 49X Ambulatory surgical care

- Each surgical procedure is assigned to one of 16 ASC rates
  - Example: Procedure code 11100-Biopsy Skin Lesion is ASC Group D
  - ASC rates are available on the IHCP fee schedule

- A maximum of two procedures will be reimbursed
  - The highest ASC rate pays 100%
  - The second highest ASC rate pays 50%
Outpatient Claims

Treatment rooms

- Treatment room revenue codes are reimbursed at an ASC rate when accompanied by a surgical procedure code (10000-69999)
  - 45X Emergency department
  - 51X Clinic
  - 52X Freestanding clinic
  - 70X Cast room
  - 71X Recovery room
  - 72X Labor/delivery room
  - 76X Treatment/observation room

- If no surgical procedure is performed, submit a treatment room revenue code with no procedure code
  - Reimbursement will be at a statewide "flat" rate for each revenue code
Outpatient Claims

Stand-alone services

- Stand-alone services include therapies, diagnostic testing, laboratory, and radiology
- Stand-alone services can be billed separately or in conjunction with treatment rooms
- Stand-alone services are reimbursed at a statewide flat rate by revenue code
  - Exception: Laboratory and radiology reimbursed at procedure code fee schedule amount
- *IHCP Provider Manual, Chapter 8, Stand-alone Services Table* gives a complete list of stand-alone revenue codes
Outpatient Claims

Add-on services

– Add-on services include drugs, IV solutions, medical supplies, blood, and oxygen

– Add-on services are separately reimbursable at a statewide flat rate by revenue code, when billed with stand-alone procedures

– Some add-on services are separately reimbursable at a statewide flat rate by revenue code, if billed with a treatment room revenue code
  • 255 Drugs incident to radiology
  • 258 IV Solutions
  • 29X DME
  • 370 Anesthesia
  • 38X Blood storage and processing
  • 39X Diagnostic supplies
Revenue Code 451

Emergency room services

– The IHCP will reimburse for a screening service when emergency room services are provided to a member whose diagnosis does not constitute an emergency

– Providers report revenue code 451 when billing for the screening service

– Payment is denied for all ancillary services reported on the same date of service as revenue code 451
Revenue Code 451

Emergency room services – Prudent layperson

– Per 42 U.S.C. 1395dd(e)(1), an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

• Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
• Serious impairment to bodily functions
• Serious dysfunction of any bodily organ or part
Home Health Services
Coverage and billing codes

- Home health services are available to members medically confined to the home, when services are ordered in writing by a physician and performed in accordance with a written plan of care.

- Home health services require prior authorization.
  
  *Exception*: Up to 120 units of RN, LPN, or home health aid services, or 30 units of therapy, within 30 days of hospital discharge when ordered in writing by physician prior to discharge.

  - Use occurrence code 50 and hospital discharge date in fields 31-34, a-b.
Home Health Services
Coverage and billing codes

- Revenue and HCPCS codes
  - 42X-G0151 – Physical therapy in home health setting
  - 43X-G0152 – Occupational therapy in home health setting
  - 44X-G0153 – Speech therapy in home health setting
  - 552-99600 – Skilled nursing home health visit (modifier TD for RN and TE for LPN/LVN)
  - 572-99600 – Home health aide home health visit
Home Health Services

Units of service

- Providers must bill each date of service as a separate line item

- Providers must bill each level of service, such as RN or LPN, as a separate line item, for each date of service

- If the same service is provided, such as multiple RN visits on the same day, the services should be combined and billed on one claim

- Home health aide, LPN, and RN visits are based on one-hour units
  - Round to the nearest unit
  - If in the home for less than 29 minutes, providers can bill for the entire first hour if a service was provided

- Therapy visits are based on 15-minute units of service
  - Round to the nearest unit
  - If therapist is in the home less than eight minutes, the service cannot be billed
Home Health Services

Overhead rate

- For each encounter at home, home health providers receive an overhead rate for administrative costs
- If the dates of service billed are not consecutive, enter occurrence code 61, and the date, for each date of service in fields 31-34, a-b
- If the dates of service are consecutive, enter occurrence code 61 and the occurrence span dates in fields 35 a-b
- Providers can only report one overhead encounter per recipient per day
  - In a multi-member situation (for example, husband and wife both treated during same encounter), only one overhead allowed
Long Term Care

Coverage

– Inpatient long-term care (LTC) services are available to IHCP members who meet the threshold of nursing care needs required for admission to, or continued stay in, an IHCP-certified facility

– Additional information about LTC coverage and billing procedures is located in the *IHCP Provider Manual, Chapter 14*

– Room and board revenue codes for nursing facilities:
  • 110 – Room and board private
  • 120 – Room and board semi-private (two beds)
  • 130 – Room and board semi-private (three or four beds)
Long Term Care
Leave days (bed-hold)

- The IHCP does not reimburse “bed-hold” days
  - LTC facilities should have their own bed-hold policies
- Bed-Hold days should be reported on the claim
  - Revenue Codes
    - 180 – Bed-hold days not eligible for payment
    - 183 – Therapeutic bed-hold days eligible for payment
    - 185 – Hospital bed-hold days eligible for payment
Long Term Care

Autoclosure

- To ensure that all IHCP members receive all the benefits to which they are entitled, it is the responsibility of each LTC provider to properly document the discharge of residents in a timely manner.

- The patient status code from the UB-04 claim form (field 17-STAT) is used to close the member’s Level of Care (LOC).
  - The patient status in field 17 is also used to close the LOC for inpatient Medicare crossovers.

- This eliminates the need to submit written discharge information to the Office of Medicaid Policy and Planning (OMPP).

- Use of incorrect status codes can result in overpayments and prevents members from receiving services, such as supplies and pharmacy prescriptions, after discharge from the LTC facility.
Hospice Services

- Hospice providers should follow the general billing guidelines for completing the UB-04 claim form and use the appropriate revenue codes as listed in the IHCP Hospice Provider Manual

- Access the IHCP Hospice Provider Manual from indianamedicaid.com

- Hospice levels of service
  - Routine home care
  - Continuous home care
  - Inpatient respite
  - General inpatient
Hospice Services

- Hospice revenue codes
  - 651 – Routine home care in private home
  - 652 – Continuous home care in private home
  - 653 – Routine home care in nursing facility
  - 654 – Continuous home care in nursing facility
  - 655 – Inpatient respite care
  - 656 – General inpatient hospice
  - 657 – Hospice direct care physician service
  - 659 – Medicare/IHCP dually eligible nursing facility members

- Type of Bill in field 4 is 822 – Special facility-hospice

- Each date of service must be entered on a separate line in fields 42-49
ESRD – End-Stage Renal Disease

- Patients who have ESRD, a chronic condition with kidney impairment considered irreversible and permanent, require a regular course of dialysis or a kidney transplant to maintain life

- Hemodialysis or peritoneal dialysis is reimbursed at a daily composite rate, which covers the cost of the dialysis session, including the durable and disposable items and medical supplies

- Nonroutine lab work and drugs may be billed separately

- Services may be provided in an outpatient hospital setting, an ESRD clinic, or in the patient’s home
ESRD – End-Stage Renal Disease

- Each date-specific service must be billed on a separate line

- Type of Bill codes
  - Freestanding renal dialysis facilities – TOB 721
  - Outpatient hospital renal dialysis facilities – TOB 131
  - Inpatient renal dialysis services – TOB 111

- Revenue Codes
  - 82X – Hemodialysis composite rate
  - 83X – Peritoneal dialysis composite rate
  - 84X – CAPD (continuous ambulatory peritoneal dialysis)/composite rate
  - 85X – CCPD (continuous cycling peritoneal dialysis)/composite rate
  - 634/635 – Epoetin (with appropriate HCPCS code)
  - 636 – Drugs (with the appropriate HCPCS code)
  - 30X – Nonroutine lab (with the appropriate HCPCS code)
Let’s Play **TRUE or FALSE**

- A home health provider who provided physical therapy and nursing services by an RN on the same day would be allowed two overhead reimbursements?
  • FALSE

- Drugs billed on the same claim with an outpatient surgery would be separately reimbursed at a statewide "flat" rate?
  • FALSE

- Critical access hospitals are exempt from the HAC/POA reporting requirements?
  • FALSE
Let’s Play **TRUE or FALSE**

- When a hospital inpatient is transferred, the receiving hospital is reimbursed a DRG prorated daily rate?
  - *FALSE*

- Outpatient services within three days of an inpatient admission should be billed separately on an outpatient claim?
  - *FALSE*

- The best way to file a UB-04 is on paper?
  - *FALSE!!!
Understand
Denial Reasons
Claim Denial Reasons

- 0558 – Coinsurance and deductible amount missing
  • A Medicare crossover claim must have coinsurance or deductible amounts present on the claim

- 4095 – Non-surgical services not reimbursed individually if performed in conjunction with an outpatient surgery
  • Outpatient surgeries are reimbursed at an all-inclusive ASC rate

- 0593 – Medicare denied detail
  • A Medicare crossover claim that has denied details will deny
Claim Denial Reasons

- 0268 – Billed amount missing
  - The billed amount is missing from field 47

- 5001 – Exact duplicate
  - Service billed has already been paid

- 3001 – Date of service not on prior authorization master file
  - Prior authorization was not obtained for service billed

- 0217 – NDC missing
  - The NDC number is missing or invalid
Helpful Tools
Avenues of resolution

- IHCP website at indianamedicaid.com

- Provider Enrollment
  • 1-877-707-5750

- Customer Assistance
  • 1-800-577-1278, or
    (317) 655-3240 in the Indianapolis local area

- Written Correspondence
  • P.O. Box 7263
    Indianapolis, IN  46207-7263

- Locate area consultant map on:
  • indianamedicaid.com (provider home page> Contact
    Us> Provider Relations Field Consultants)
  or
  • Web interChange > Help > Contact Us
Q&A