



## UB-92 Billing Instructions

### Revision Table

Revision Date	Sections Revised	Description
7/1/02	Section 2.3 – Form Locator 42 and 46	Language is being added to clarify UB-92 billing instructions for form locator 42 to reflect appropriate leave of absence revenue codes for nursing homes and assisted living facilities. Both state and non-state long term care facilities will use leave of absence codes 0183, 0185, and 0189. Assisted living facilities will use only 0189. In addition, form locators 42 and 46 have been updated to reflect the 4-digit revenue codes.
3/14/05	Section 2.6	Added instructions for billing emergency room co-pays.
11/14/05	Appendix C	Updated to reflect the current patient status codes.
2/24/06	Section 2.3	Updated the instructions for completing Type of Bill.
3/21/06	2.3, Locator 4	Removed reference to claims containing more than 23 lines.
3/21/06	2.10	Added instructions for billing claims with over 23 lines.
6/26/06	Appendix C	Revised to include effective and end dates for each code. Also added codes 43, 64, 65 and 66.

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## **UB-92 Billing Instructions**

### **Table of Contents**

#### **1.0 Introduction**

#### **2.0 Billing Instructions**

- 2.1 Introduction
- 2.2 General Procedures
- 2.3 Completion of the UB-92
- 2.4 UB-92 Claim Form
- 2.5 Completion of Medicare/Medicaid Related Claims for UB-92
- 2.6 Billing for Emergency Room Co-Pays
- 2.7 Attachments
- 2.8 Out-of State Providers
- 2.9 Sterilizations
- 2.10 Billing Claims with Over 23 Lines

#### **3.0 Appendix A - Admission/Accident/Discharge Code Structure**

#### **4.0 Appendix B – Type of Admission Code Structure**

#### **5.0 Appendix C – Patient Status Code Structure**

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## **1.0 Introduction**

The Department of Health and Social Services establishes all policies and procedures governing the Delaware Medical Assistance Program. The General Policy and Provider Specific Policy manuals are to be referenced for all program guidelines.

EDS is the Delaware Medical Assistance Program Fiscal Agent. Providers are to bill EDS for the care and services rendered to DMAP clients.

This Billing Manual has been designed as a reference tool to be utilized by DMAP providers when submitting claims for payment. This manual should be used in conjunction with the General Policy and Provider Specific Manuals. The submission of proper and complete billing documents by providers is essential for timely and accurate claims processing and payment.

Initially, providers should carefully read this manual to become familiar with the contents. The manual should then be referenced when completing billing documents or forms. EDS will periodically update the Billing Manual on the DMAP Web site. Providers can opt to have paper updates sent through the mail. Revised pages should be promptly inserted into the manual for quick and accurate future reference.

This manual includes a chapter on the completion of claim forms and billing documents for all provider types that bill using the UB-92 claim form.

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## 2.0 Billing Instructions

### 2.1 Introduction

The UB-92 claim form is used by inpatient and outpatient hospitals, long term care and assisted living facilities, hospice, and home health providers in billing DMAP programs for services provided to eligible Medicaid clients. Each client's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important.

### 2.2 General Procedures

- Verify the client's eligibility through the Voice Response System, the Internet, Provider Electronic Solutions, or a swipe card reader.
- File claims within time limits specified in the General Policy Section of this manual.
- Use only original UB-92 claim forms with the red drop out ink or file electronically.
- Ensure that all paper claims submitted for payment are signed in black ink or a signed trading partner agreement is on file at EDS.
- Ensure that handwritten claims are completed using dark black ink.
- Ensure that all required attachments are included, i.e. Explanation of Medical Benefits (EOMB) from third party insurance coverage.
- Mail the completed claims to the following address:

**EDS**

**P.O. Box 909, Manor Branch**

**New Castle, DE 19720-0909**

### 2.3 Completion of the UB-92

This section provides specific instructions for completing the UB-92 claim form for the DMAP programs. The numbered items correspond to the form locators on the claim form. Ditto marks (" ") are not allowed to reference the information on the preceding line. Items that are required for all UB-92 billing are indicated with an A. Optional items are indicated by an O and items that are required based on provider type and specific policy are indicated with an R.

Form Locator	Name	Requirement Code	Instructions for Completing
1	Provider Name, Address and Telephone Number	A	Enter the provider's name, address, city, ZIP code and telephone number
2	Unassigned Data Field	O	Not required
3	Patient Control Number	O	The provider may enter a patient control number in this field for accounting purposes. Enter the client's account number, if applicable. Up to ten numeric or alphabetic characters will be accepted. The patient control number will appear on the Remittance Advice (RA).
4	Type of Bill	A	Listed below are the valid types of bills accepted: Inpatient Hospitals - 111, 112, 113, 114, 117 and 118  Home Health – 331, 332, 333, 334, 337, 338  Hospice – 813, 817, 818, 823, 827, 828  LTC and Assisted Living – 212, 213, 214, 216, 217, 218  Outpatient – 131, 137, 138  PPEC – 891, 897, 898
5	Federal Tax ID	O	Not required
6	Statement Covers	A	Required field. Enter the beginning and ending dates of the period included on this bill.
7	Covered Days	R	Required for Inpatient and Hospice claims. Enter the number of covered days. The discharge date should not be counted as a covered day.
8	Non-covered Days	R	Required for LTC providers if billing for LOA days. Enter the days of care not covered.
9	Coinsurance Days	O	Not required

<b>Form Locator</b>	<b>Name</b>	<b>Requirement Code</b>	<b>Instructions for Completing</b>
10	Lifetime Reserve Days	O	Not required
11	Unassigned Data Field	O	Not required
12	Patient's Name	A	Required field. Enter the client's last name, first name, and middle initial exactly as it appears on the current Medical Assistance Identification Card.
13	Patient's Address	O	Enter the client's full mailing address including street number and name (post office box or RFD), city name, state name and zip code.
14	Patient's Date of Birth	O	Enter the client's date of birth exactly as it appears on the current Medical Assistance Identification Card.
15	Patient's Sex	O	Enter M for male or F for female
16	Patient Marital Status	O	Enter the client's marital status
17	Admission Date	R	Required for Inpatient and LTC. Enter the date of admission for inpatient services.
18	Admission Hour	R	Required for Inpatient and LTC. Enter the national code that corresponds to the hour during which the client was admitted for inpatient care. Refer to Appendix A for code structure. 99 is not acceptable.
19	Type of Admission	R	Required for Inpatient and LTC. Enter the national code indicating the priority of this admission. Refer to Appendix B for valid codes. 9 is not acceptable.
20	Source of Admission	O	Not required
21	Discharge Hour	R	Required for Inpatient. Enter the hour that the client was discharged from inpatient care. Refer to Appendix A for valid codes.
22	Patient Status	R	Required for Inpatient, LTC and Hospice. Enter the code indicating the client's status as of the statement covers through date. Refer to Appendix C for code structure.
23	Medical Record No.	O	This is an optional field that the provider may use for entering the patient's medical record number.
24-30	Condition Codes	O	The code(s) used to identify conditions relating to this bill that may affect payer processing.
31	Unassigned Data Field	O	Not required
32-35	Occurrence Codes and Dates	O	Refer to the Uniform Billing Training Manual for the code and associated

Form Locator	Name	Requirement Code	Instructions for Completing
			date defining a significant event relating to this bill.
36	Occurrence Span Code and Dates	O	Not required
37	Unassigned Data Field	O	Not required
38	Responsible Party Name	O	The provider may use this field to enter the name, address, county and telephone number of the responsible party.
39-41	Value Codes and Amounts	O	Not required
42	Revenue Codes	A	<p>Hospital: Enter the revenue code that corresponds to the revenue description in Form Locator 43. Refer to the Uniform Billing Training Manual for valid revenue codes. The last entry on the claim detail lines should be 0001 for Total Charges.</p> <p>PPEC: Use the revenue code that appears on the approved prior authorization letter for covered services.</p> <p>LTC State Facility: Use revenue code 0100 for room and board, plus ancillary</p> <p>LTC Non-State/Assisted Living Facility: Use revenue code 0101 for room and board, without ancillary. Use appropriate revenue code for covered ancillary service</p> <p><b>Leave of Absence Codes</b></p> <p>LTC – State and Non-State Facilities: Use leave of absence revenue codes 0183, 0185 and 0189 as appropriate.</p> <p>Assisted Living Facilities: Use <b>only</b> 0189 as a leave of absence code. No payment is made for days billed with revenue code 0189. This revenue code should be used for any days when the client is out of the facility for the entire day.</p>
43	Revenue Description	A	Enter a narrative description of the related revenue categories (FL 42)

Form Locator	Name	Requirement Code	Instructions for Completing
			included on this bill. Accommodations must be entered in revenue code sequence on the UB-92.
44	HCPCS Rates	A	For inpatient and nursing home claims, record any applicable accommodation rate in this field. For outpatient claims, record any applicable HCPCS codes in this field.
45	Service Date	O	Enter the date of service for each service provided in MM/DD/CCYY format. Each date of service must be billed on a separate detail line when billing with procedure codes. Exceptions: Multiple-day service codes, codes requiring an RR modifier, and YY201 and YY205 for Hospice providers for dates of service prior to 7/1/02.
46	Units of Service	A	Enter the quantitative measure of services by revenue category provided to the client including such items as number of accommodation days or special treatments. The cumulative units for accommodation revenue codes 0100-0210, as shown in Form Locator 46, must equal the units billed in Form Locator 7. Enter only the units that apply to the covered days.
47	Total Charges	A	Enter the total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
48	Non-covered Charges	O	Non-covered days and/or non-covered charges may be entered in Form Locator 48.
49	Unassigned Data Field	O	Not required
50	Payer	R	Required if other insurance had paid. Enter the name of the payer and the NEIC. The EOB or remittance from the third party carrier must be attached to the claim before payment can be made. The client should be questioned to determine if other coverage is carried.
51	Provider Number	A	Enter the ten-digit DMAP provider number.
52	Release of Information – Certification Indicator	O	Not required

<b>Form Locator</b>	<b>Name</b>	<b>Requirement Code</b>	<b>Instructions for Completing</b>
53	Assignment of Benefits – Certification Indicator	O	Not required
54	Prior Payment	R	Required if a commercial insurance carrier made payment. Indicate the amount paid by the other insurance carrier. Do not indicate Medicare payments in this field.
55	Estimated Amount Due	O	Not required
56	Unassigned	O	Enter the Coinsurance and Deductible amounts Medicare Part A and Part B, applied toward this bill. Refer to the Medicare/Medicaid related claims section for additional instructions.
57	Unassigned	O	Not required
58	Insured's Name	A	Enter the client's last name, first name and middle initial exactly as it appears on the Medical Assistance Identification Card. If the client is covered by insurance other than Medicaid, enter the name of the individual in whose name the insurance is carried as qualified by Medicaid.
59	Patient's Relationship to Insured	A	Enter the appropriate code as referenced in the Uniform Billing Training Manual indicating the relationship of the client to the identified insured.
60	Cert, SSN, HIC ID No.	A	Enter the client's Delaware Medical Assistance Identification Number
61	Insurance Group Name	R	Required if other insurance has paid. Enter the insured's group plan name if another payer insures the client.
62	Insurance Group Number	R	Required if other insurance has paid. Enter the insured's group plan number if another payer insures the client.
63	Treatment Authorization Code	R	<p>Acute Care Inpatient Hospitals and Certified Physical Rehab Wings of Acute Care Inpatient Hospitals must obtain Prior Authorization for services provided outside of DMAP's region that includes Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia.</p> <p>Inpatient Rehabilitation hospitals and Specialty hospitals must obtain prior authorization for all services provided (see specific billing information in the</p>

<b>Form Locator</b>	<b>Name</b>	<b>Requirement Code</b>	<b>Instructions for Completing</b>
			Inpatient Provider Specific Policy Manual)
64	Employment Status Code	O	Not required
65	Employer Name	O	Based upon Form Locators 61-62, enter the name of the employer that provides health care coverage for the individual identified in Form Locator 58.
66	Employer Location	O	Enter the specific location of the employer of the individual identified in Form Locator 58.
67	Principle Diagnosis Code	A	Enter the ICD-9-CM diagnosis code for the principle diagnosis appearing in Form Locator 68-75. The diagnosis should reflect the information contained in the client's medical record for the current stay.
68-75	Other Diagnosis Codes	O	Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.
76	Admitting Diagnosis	R	Required for Inpatient and LTC. Enter the ICD-9-CM diagnosis code corresponding to the diagnosis of the client's condition that prompted admission to the hospital.
77	External Cause of Injury	O	Not required
78	Unassigned Data Field	O	Not required
79	Procedure Coding Method Used	A	Enter code 5
80	Principle Procedure Code	O	If applicable enter the ICD-9 primary procedure code and date on which the procedure was performed during the billing period as shown in the client's medical record. In determining which of several procedures is the principle, refer to the Uniform Billing Training Manual.
81	Other Procedure Codes	O	Required if a principle procedure code, and dates have been entered in FL 80.
82	Attending Physician Id	A	Enter the Delaware Medical Assistance provider number for the physician attending the client. If the physician is non-participating in the Medical Assistance program, enter his or her

Form Locator	Name	Requirement Code	Instructions for Completing
			last name. It is the provider's responsibility to obtain the attending physician's Delaware Medical Assistance provider number. This is the physician primarily responsible for the care of the client from the beginning of the hospitalization or long-term care stay.
83	Other Physician ID	R	Required if FL 81 and 82 have been entered. Enter the Delaware Medical Assistance provider number of the operating surgeon. If the physician is non-participating in the Medical Assistance program, enter his or her last name. It is the provider's responsibility to obtain the surgical physician's Delaware Medical Assistance provider number.
84	Remarks	O	This field may be used to include information relative to processing the claim.
85	Provider Representative	A	The provider or designated authorized individual must sign and date the claim certifying that the services were rendered by the provider. "Provider's signature" is defined as the signature of an individual authorized by the provider rendering the service. The name of a hospital or group is not acceptable. All signatures must be original ink signatures – Black ink only. No rubber stamps or photocopied signatures are acceptable.
86	Date Bill Submitted	A	Enter the date the bill was signed or sent to EDS for payment

## 2.4 UB-92 Claim Form

The National Uniform Billing Committee is responsible for the design of the UB-92 (Form CMS-1450) form.

Optical Character Recognition (OCR) equipment is utilized in Delaware to process paper claims. Those providers submitting paper claims must use the scannable, red ink version of the UB-92. These red ink versions of the form can be purchased from the Standard Register Company. Their phone number may be found in your local yellow pages.

## 2.5 Completion of Medicare/Medicaid Related Claims for UB-92

If medical services are provided to a client who is entitled to Medicare under the Social Security Act and also to Medicaid benefits, it is necessary that you file a claim with Medicare first. After you receive payment from Medicare, you may file a claim to Medicaid, either on paper or electronically as appropriate, for reimbursement consideration.

In order to submit a Medicare/Medicaid claim to EDS, you must submit an original UB-92 claim with the following fields altered from what you sent to Medicare:

- Field 51 - complete this field with the billing Delaware Medicaid Provider Number,
- Field 58 - complete this field with the name of the client,
- Field 60 - complete this field with the client's identification number,
- Field 85 - complete this field with an original, black ink, signature.

You must attach a copy of the Medicare EOMB to the claim with the client's name circled. Highlighting your EOMB is discouraged as it will not scan well. Each Medicare/Medicaid client listed on the EOMB must have a separate claim filed with an EOMB attached to his or her claim form.

Any charges denied by Medicare will not be paid by Medicaid with the exception of:

- Those services not covered by Medicare but covered by Medicaid, or
- Services covered by both Medicare and Medicaid but with different limits or criteria. In these instances Medicaid will determine coverage on the basis of its own policy.

## 2.6 Billing for Emergency Room Co-Pays

To bill an emergency room co-pay the following fields need to be completed:

- Field 42 – Enter the correct emergency room revenue code
- Field 44 – Enter the procedure code
- Field 47 – Enter the amount of the ER co-pay
- Field 54 – Leave blank

A copy of the TPL voucher must be attached. Indicate on the voucher the column that shows the co-pay or patient responsibility amount.

Providers who bill electronically would follow the same procedures by completing the Procedure Code and Billed Amount fields. In the Other Insurance Reason Code field, fill in the appropriate code for co-pay billing.

## **2.7 Attachments**

When a client has third party insurance coverage, you must attach a copy of the remittance advice from the third party insurance carrier. If the carrier denied the claim, you must attach the denial remittance advice to show you have filed the claim.

Refer to the Provider Specific Section of this manual for a list of services that require attachments. If the claim does not have the appropriate attachment, your claim will deny.

## **2.8 Out-of State Providers**

Out-of-State providers must bill the Delaware Medical Assistance Program following the instructions outlined in the manual. You must utilize the Delaware Medicaid HCPCS procedure codes when billing the Delaware Medical Assistance Program.

## **2.9 Sterilizations**

Charges for deliveries and sterilizations must be combined on the same claim form. Please refer to the Provider Specific Section of your Provider Manual for proper completion of Consent/Awareness Forms.

## **2.10 Billing Claims with Over 23 Lines**

Claims containing more than 23 lines must generally be submitted electronically.

- If the submission contains more than 23 lines and also requires an attachment and is from an inpatient or outpatient hospital, contact the EDS Provider Relations Manager for instructions.
- If the submission contains more than 23 lines and also requires an attachment and is not from an inpatient or outpatient hospital, divide the claim into multiple paper claims and submit with needed attachments.

### 3.0 Appendix A - Admission/Accident/Discharge Code Structure

Code	Time (am)	Code	Time (pm)
00	12:00 - 12:59 midnight	12	12:00 - 12:59 noon
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:50

**99 - Not acceptable**

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## 4.0 Appendix B – Type of Admission Code Structure

1. Emergency -The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the Emergency Room.
2. Urgent - The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.
3. Elective - The client's condition permits adequate time to schedule the availability of a suitable accommodation.
4. Newborn - Use of this code necessitates the use of special Source of Admission codes - see Form Locator 20.

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## 5.0 Appendix C – Patient Status Code Structure

Code	Description	Effective Date	End Date
01	Discharged to home or self care (routine discharge)	01/1/1990	
02	Discharged/transferred to a short-term general hospital for inpatient care	01/1/1990	
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care	01/1/1990	
04	Discharged/transferred to an intermediate care facility (ICF)	01/1/1990	
05	Discharged/transferred to another type of institution not defined elsewhere in this code list	01/1/1990	
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care	01/1/1990	
07	Left against medical advice or discontinued care	01/1/1990	
08	Discharged/transferred to home under care of home IV provider	01/1/1990	10/01/2005
09	Admitted as an inpatient to this hospital	01/1/1990	
20	Expired	01/1/1990	
30	Still Patient	01/1/1990	
40	Expired at home	01/1/1990	
41	Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)	01/1/1990	
42	Expired - place unknown	01/1/1990	
43	Discharged/transferred to a federal health care facility	10/01/2003	
50	Hospice – home	01/1/1990	
51	Hospice – medical facility	01/1/1990	
61	Discharged/transferred to hospital-based Medicare approved swing bed	01/1/1990	
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital	01/1/1990	
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)	01/1/1990	
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare	10/01/2002	
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	04/01/2004	
66	Discharged/transferred to a Critical Access Hospital (CAH)	01/01/2006	
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care	01/1/1990	04/01/2003
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care	01/1/1990	04/01/2003

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