

UB-04 Billing Guide for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Purpose of the Document	<p>The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the UB-04 claim form:</p> <ul style="list-style-type: none">• Extended Care Facilities <p>Including, Intermediate Care Facilities for the Mentally Retarded, Intermediate Care Facilities for Other Related Conditions and State MR Centers.</p>
Document Format	<p>The document contains a table with five columns and each column provides a specific piece of information as explained below:</p> <ul style="list-style-type: none">• Form Locator Number – Provides the field number as it appears on the claim form.• Form Locator Name – Provides the field name as it appears on the claim form.• Form Locator Code – Lists one of four codes that denotes how the Form Locator should be treated. They are:<ul style="list-style-type: none">• M – Indicates that the Form Locator must be completed.• A – Indicates that the Form Locator must be completed, if applicable.• O – Indicates that the Form Locator is optional.• LB – Indicates that the Form Locator should be left blank.• Notes – Provides important information specific to completing the Form Locator number field. In some instances, the Notes section will indicate provider specific Form Locator completion instructions.
Font Sizes	<p>Because of limited field size, either of the following type faces and sizes are recommended for form completion:</p> <ul style="list-style-type: none">• Times New Roman, 10 point• Arial, 10 Point <p>Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.</p>
Signature Approval	<p>Each batch of claims submitted MUST be accompanied by 1 (one) properly completed Signature Transmittal Form (MA 307). A batch can consist of a single claim or as many as 100 claims.</p> <p>Go to the DHS Website to download a copy of the form.</p>
Medical Assistance is Payor of Last Resort	<p>All other insurance resources maintained by a medical assistance beneficiary must be billed first before medical assistance is billed for all medical services.</p>

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Special Instructions for Long Term Care Facilities

All Medicare Coinsurance Days:

When submitting a claim for a service period where all days are Medicare Coinsurance Days, use these instructions for the following Form Locators:

Coinsurance

Form Locators 39a - 41d - When submitting a claim for a service period where all of the days are Medicare Coinsurance Days and there were 30 days in the service period; enter 30 with the appropriate value code in Form Locator 39a through 41d. If there were 31 days within the service period and all days were Medicare Coinsurance Days, enter 31. Value codes should be entered in numerical sequence starting in Form Locators 39a through 41a, 39b through 41b, 39c through 41c and lastly 39d through 41d.

Form Locators 18 - 28 (Condition Codes) - Enter **X2**.

Form Locator 42 (Rev Cd) – Enter Revenue Code **0100**.

Form Locator 43 (Description) – Enter **Facility Days**.

Form Locator 44 (HCPCS/Rate) – Enter MA rate.

Form Locator 46 (Serv Units) – Enter a zero (**0**).

Form Locator 47 (Total Charges) – Enter the Medical Assistance rate times the number of coinsurance days as the Total Charges.

All other Form Locators on the UB-04 must be completed as per the billing guide.

Submitting Claims for Medical Assistance (MA) Days and Medicare Coinsurance Days in the Same Service Period

If you are submitting a claim for a service period where you are billing for any combination of Medicare Coinsurance Days, Facility Days, Therapeutic Leave Days, and/or Hospital Reserve Bed Days, do not include your MA Coinsurance Share amount in the Total Charge. PROMISe™ will process your MA coinsurance share in this instance based on the number of days in Form Locators 39a through 41d with value code 82, and the amount Medicare paid for the coinsurance days in Form Locator 54 (Prior Payments), and your facility specific per diem rate on file.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Other Special Instructions for Long Term Care Facilities	NPI Registration – Refer to Bulletin number 99-06-14
	Prudent Payment – Refer to Bulletin number 99-06-04
	ESC 2550 (Medicare Non-Coverage for Medicare Eligible Nursing Facility Residents – Refer to Bulletin number 03-07-01

Special Instructions for Long Term Care Facilities

Medicare Non-Coverage Instructions

The specific instances where you may submit a claim with the following instructions include Provider Notice of Medicare Non-Coverage, which include:

- There was no 3-day prior hospital stay;
- The resident was not transferred within 30-days of a hospital discharge;
- The resident's 100 benefit days are exhausted;
- There was no 60-day break in daily skilled care;
- Medical Necessity Requirements are not met;
- Daily skilled care requirements are not met.

Do not use these billing instructions unless one of the six criteria listed above apply.

When submitting claims via the UB-04 for services not covered by Medicare the following instructions should be followed:

- ❑ **Form Locators 18 - 28 (Condition Codes)** – Enter X4, when one of the above-listed criteria is applicable to the nursing facility service for which you are billing.
- ❑ **Form Locator 80 (Remarks)** – Enter:
 - No 3-Day Prior Hospital Stay;
 - Not Transferred Within 30 Days of Hospital Discharge;
 - 100 Benefit Days Exhausted;
 - No 60 Day Break in Daily Skilled Care;
 - Medical Necessity Requirements Not Met;
 - Daily Skilled Care Requirements Not Met.

For example, if there was no 3-day prior hospital stay, enter “No 3-day prior hospital stay”. All other Form Locators of the UB-04 must be completed as per the billing guide.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
1	Provider Name, Address and Telephone Number	M M M O	Enter the information in Form Locator 1 on the appropriate line: Line 1 – Provider Name Line 2 – Complete street address Line 3 – City, state, and zip code Line 4 – Area code and telephone number
2	Pay To	LB	Do not complete this Form Locator.
3 A	Patient Control Number	M	Enter the resident's unique, alpha, numeric, or alphanumeric number that was assigned by the provider. You may enter up to 24 characters. DHS will capture and return up to 24 characters. When this Form Locator is completed, your resident's account number will appear on the RA Statement and will make it easier to identify those claims where the beneficiary identification number is not recognized by DHS.
3 B	Medical Record	O	Enter the resident's medical record number up to 24 alphanumeric characters. <i>The medical record number will not be returned on the RA Statement.</i>
4	Type of Bill	M	A UB-04 claim form may be used to bill for long-term care or to replace a claim for long term care that was paid by MA. Enter the appropriate 3-character code to identify the type of bill being submitted. The format of this 3 character code is indicated below: 1. First character: Type of facility – always enter “6” to indicate Intermediate Care Facility. 2. Second character: Bill classification – always enter “5” to indicate Intermediate Care, Level I. 3. Third character: Frequency – Enter 0, 1, 2, 3, 4, 7, or 8. 0 – Non Payment/Zero Claim This code is to be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill; but needs to inform the payer of the non-reimbursable periods of confinement or termination of care (i.e., where patient pay is equal to

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
			or exceeds the amount billed).
4	Type of Bill	M	<p>1 – Admit Through Discharge Claim</p> <p>This code is to be used for a bill, which is expected to be the only bill to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or course of treatment, and bills, which represent an entire period of the primary third party payer.</p> <p>2 – Interim – First Claim</p> <p>This code is used for the first of a series of bills to the same payer for the same confinement.</p> <p>3 – Interim – Continuing Claim</p> <p>This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted.</p> <p>4 – Interim – Last Claim</p> <p>This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will not be submitted (i.e., discharge from the facility).</p> <p>7 – Replacement of a Prior Claim</p> <p>This code is to be used when a specific bill has been issued for a specific Provider, Resident, Payer, Insured and “Statement Covers Period” and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill.</p> <p>This code replaces a prior claim. It does not simply adjust a prior claim. (Frequency Code 7 cannot be used to correct beneficiary or provider number errors. For those errors, submit bill with Frequency Code 8.)</p> <p>Note: Refer to Form Locator 80 for Adjustment Reason Codes.</p>

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
			<p>8 – Void/Cancel of Prior Claim</p> <p>This code reflects the elimination of <u>all</u> previously paid claims in their entirety for a specific Provider, Resident, Payer, Insured and “Statement Covers Period”.</p> <p>Refer to the UB-04 Desk Reference for Long Term Care Facilities, located in Appendix A of the handbook.</p>
5	Federal Tax Number	LB	Do not complete this Form Locator.
6	Statement Covers Period From/Through	M	<p>Enter the first service date in the From portion of this Form Locator and the last service date in the Through portion of this Form Locator in a 6-digit format (mmddy).</p> <p><u>If the resident was discharged from the facility</u>, the From portion will contain the first service date for the calendar month and Through portion will contain the discharge date. When submitting a claim for a calendar month where the resident was discharged, use the applicable type of bill in Form Locator 4 (i.e., 0261 or 0264) and indicate the applicable patient status code in Form Locator 17.</p> <p>When entering dates do not use spaces, slashes, dashes, or hyphens. (mmddy)</p>
7	Unlabeled	LB	Do not complete this Form Locator.
8 A	Patient Name - ID	LB	Do not complete this Form Locator.
8 B	Patient Name	M	Last name, first name and middle initial of the resident.
9 (A-E)	Patient Address	LB	Do not complete this Form Locator.
10	Birth date	O	Enter the birth date of the resident in an 8-digit format. Do not use spaces, slashes, dashes, or hyphens (i.e. mmddccyy).
11	Sex	O	Enter M for Male or F for Female.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
12	Admission Date	M	Enter the admission date for the resident's current stay in the facility. Enter the date in a 6-digit format. Do not use slashes, dashes, or hyphens (e.g., mmddyy).
13	Admission Hour	LB	Do not complete this Form Locator.
14	Admission Type	LB	Do not complete this Form Locator.
15	Admission Source	M	Enter the appropriate code to identify from where the resident was admitted. <i>For a complete listing and description of Admission Source Codes, refer to the UB-04 Desk Reference for Long Term Care Facilities, located in Appendix A of the handbook.</i>
16	Discharge Hour	LB	Do not complete this Form Locator.
17	Patient Status	M	Enter the appropriate patient status code. When submitting interim bills, enter Patient Status Code 30 in this Form Locator. If the resident was discharged from the facility during the service month, enter the appropriate code to identify the reason for discharge. <i>For a complete listing and description of Patient Status Codes, refer to the UB-04 Desk Reference for Long Term Care Facilities, located in Appendix A of the handbook.</i>
18 Through 28	Condition Codes	A	Enter the appropriate condition code. Note: For Medicare Non-Coverage Instructions, see page 2: <i>For a complete listing and description of Condition Codes, refer to the UB-04 Desk Reference for Long Term Care Facilities, located in Appendix A of the handbook.</i>
29	Accident State	LB	Do not complete this Form Locator.
30	Unlabeled		

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
Line 1	(Full Medicare Days)	A	Enter number of days paid by Medicare.
Line 2	Unlabeled	LB	Do not complete this portion of the Form Locator.
31 (a,b) Through 34 (a,b)	Occurrence Codes and Dates	A	<p>Enter the appropriate occurrence code and date. Enter dates in a 6-digit format (mmddyy) without slashes, dashes, or hyphens.</p> <p>Occurrence codes should be entered in numerical sequence. Note: Form Locators 31a through 34a must be completed prior to completing 31b through 34b.</p> <p>Note: If you entered the four sets of hospitalization dates in Form Locator 35 and 36, enter Occurrence Span Code 74 and the <u>remaining hospitalization dates</u> in Form Locators 31a through 34b.</p> <p>Example: If the resident was hospitalized five times within the calendar month in which you are billing, the first four sets of hospitalization dates would be entered in Form Locators 35 and 36, using Occurrence Span Code 74. The fifth set of hospitalization dates would be entered in Form Locator 31. Enter Occurrence Span Code 74, with the hospital admission date in 31a. In 32a, enter Occurrence Span Code 74 with the last full date of hospitalization.</p> <p>Note: If a resident was hospitalized in the month prior to the service month, include these dates in the hospitalization items.</p> <p><i>For a complete listing and description of Occurrence Codes, refer to the UB-04 Desk Reference for Long Term Care Facilities, located in Appendix A of the handbook.</i></p>
35 (a,b) Through 36 (a,b)	Occurrence Span Codes and Dates	A	<p>Enter Occurrence Span Code 74 with the admission date and the last full date of hospitalization for each period of hospitalization during the service month in an 6-digit (mmddyy) format. The hospitalization period(s) should be broken out by month, if the hospitalization overlaps two consecutive months. (Do <u>not</u> include discharge day.)</p> <p>Note: If a resident was hospitalized in the month prior to the service month, include these dates in the hospitalization items. Additionally, if a claim for the month following the service month was previously approved for payment by MA and contained periods of hospitalization, include these dates.</p>

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
37	Unlabeled	LB	Do not complete this Form Locator.
38	Unlabeled (Assigned ICN)	LB	Do not complete this Form Locator.
39 (a – d) Through 41 (a – d)	Value Codes and Amounts	A	<p><u>Patient Pay</u> – These fields are used to report gross patient pay, net patient pay, drug deductions, insurance premiums, and medical expenses. Value codes should be entered in numerical sequence. Enter a whole dollar amount in each locator when using value codes 23 through 66. Enter days in each locator for value codes 80, 81 and 82. Do not list value codes if zero. <u>Form Locators 39a through 41a must be completed prior to completing 39b through 41b.</u> The following value codes may be used in Form Locators 39a through 41d:</p> <p>23 - Gross Patient Pay Amount 25 - Drug Deductions 31 - Lifetime Other Medical Expenses (related to facility services) 34 - Other Medical Expenses 35 - Health Insurance Premiums 66 - Net Patient Pay Amount</p> <p>Example: If reporting drug deductions, enter Value Code 25 and the amount of the resident’s drug deductions for the service month in Form Locator 39a through 41d.</p> <p>Note: Most drugs are covered through Outpatient Programs. Deductions should be minimal and include prescription drugs only.</p> <p>Note: When using any of these patient pay value codes, the amount entered should be documented on the Resource Computation Worksheet (MA 313C).</p> <p><u>Days</u> - These fields are also used to report the number of covered, non-covered and coinsurance days.</p> <p>80 - Covered Days 81 - Non-covered Days 82 - Coinsurance Days</p> <p>Note: For example days 1-9 would be entered in the same position you would enter 1-9 cents. Days 10-99 would be entered in the same positions you would enter ten to ninety-nine cents. Days 100-999</p>

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
			<p>would be entered in the same positions you would enter one dollar to nine dollars and ninety-nine cents. These value codes will then be mapped to the appropriate field on the claim inquiry window and will also be included in the value code window with the corresponding number of days displayed as dollars and cents.</p> <p><i>For a complete listing and description of Value Codes, refer to the UB-04 Desk Reference for Long Term Care Facilities, located in Appendix A of the handbook.</i></p>

See the Sample Fields Exhibit below:

Correct:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	1000 00	25	250 50	66	749 50
b	80	25	82	02		
c						
d						

Value codes must be entered in numeric sequence, starting in Form Locators 39a through 41a, 39b through 41b, 39c through 41c, and lastly 39d through 41d.

Incorrect:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	82	02	25	250 50	23	1000 00
b	66	749 50	80	25 00	31	0
c						
d						

Value Codes are NOT in numerical order.

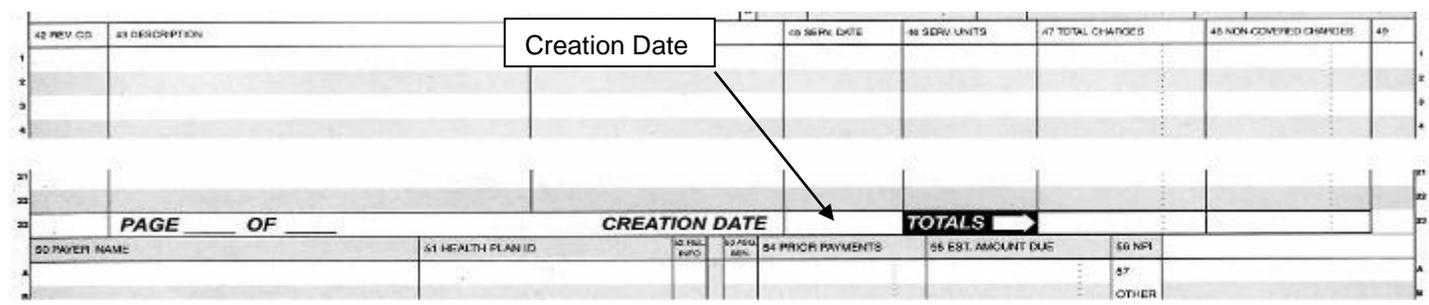
This represents 2500 days, NOT 25!

Do not list Value Codes if zero.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
42 Line 1	Revenue Code	M	Use Revenue Code 0100 (Facility Days) to report facility days, Revenue Code 0183 (Leave Days) to report therapeutic leave days, and Revenue Code 0185 (Hospital Days) to report hospital reserve bed days.
Lines 2-22		A	If you are billing for hospital reserve bed days and the resident was hospitalized for more than 15 consecutive days, be sure to include any days beyond the 15 th day as a non-covered day(s) in Form Locator 39a through 41d. Enter complete hospitalization stay as an occurrence span code in Form Locators 35 and 36. Note: A resident receiving ICF/MR or ICF/ORC services is eligible for a maximum of 15 consecutive hospital reserve bed days per hospitalization.
Line 23		LB	If you are billing for therapeutic leave days in excess of 75 per resident/per calendar year for ICF/MR or ICF/ORC residents, be sure to include any days beyond the 75 th as a non-covered day(s) in Form Locators 39a through 41d. Note: A resident receiving ICF/MR or ICF/ORC services is eligible for a maximum of 75 therapeutic leave days per calendar year.
43 Line 1	Description	M	Do not complete this portion of the Form Locator.
Lines 2-22		A	Enter the appropriate narrative description to correspond to the related revenue codes found in Form Locator 42.
Line 23	Page _ of _	LB	0100 - Facility days 0183 - Therapeutic leave days 0185 - Hospital reserve bed days
44 Lines 1-22	HCPCS	A	Do not complete this portion of the Form Locator. Note: The back side of the claim form must be left blank. DHS is not currently accepting double-sided, data-populated claim forms.
			Enter your per diem rate.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
	Codes/Rates/HIPPS Code		
45 Lines 1-22 Line 23	Service Date Creation Date	LB M	Do not complete this portion of the Form Locator. Enter 6 digit (mmddy) date when claim was completed.
			
46 Line 1 Lines 2-22	Service Units	M A	Enter the number of days (units). Enter the applicable number of days (units).
47 Line 1 Lines 2-22 Line 23	Total Charges Totals	M A M	Enter total charge calculations for each revenue code on the appropriate corresponding lines for the current billing period. Note: Claim and claim adjustment submissions must include only positive dollar amounts. Enter sum of total charge calculations in this portion of the Form Locator.
48 Lines 1-23	Non-covered Charges	LB	Do not complete this Form Locator.
49 Lines 1-23	Unlabeled	LB	Do not complete this Form Locator.
Note: Form Locators 50 through 65, lines A, B, and C, are designed to accommodate payer information.			

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
			<ul style="list-style-type: none"> Line “A” denotes the primary payer, Line “B” denotes the secondary payer, and Line “C” denotes the tertiary payer. <p>Codes:</p> <ul style="list-style-type: none"> Medicare “A” or Medicare or Medicare Advantage Plans = 2 Other Insurance = 1 and name of plan. Medical Assistance = MAPA <p>Possible Payer Combinations:</p> <p>Medical Assistance is the only payer (the beneficiary does not have any other resources):</p> <ul style="list-style-type: none"> Complete 50(A) with the word MAPA. <p>Medicare “A” or Medicare or Medicare Advantage Plans is primary and Medical Assistance is secondary:</p> <ul style="list-style-type: none"> If Medicare “A” or Medicare or Medicare Advantage Plans is primary, complete 50(A) with the number 2. Complete 50(B) with MAPA. <p>Other insurance is primary and Medical Assistance is secondary:</p> <ul style="list-style-type: none"> If other insurance is primary, complete 50(A) with the number 1 and the name of the primary insurance plan (for example, 1 Capital Blue Cross). Complete 50(B) with MAPA. <p>The patient has two other insurance plans, and Medical Assistance:</p> <ul style="list-style-type: none"> If Medicare “A” is the primary insurance plan, complete 50(A) with the number 2. If another insurance plan is primary, complete 50(A) with the number 1 and the name of the primary insurance plan (for example, 1 American General) Complete 50(B) with the number 1 and name of the secondary insurance plan (for example, 1 Capital Blue Cross) Complete 50(C) with MAPA. <p>When completing Form Locators 50 through 65, place the information applicable to the primary payer on line “A”, the secondary payer on line “B”, and the tertiary payer on line “C”.</p>
50 (A, B, C)	Payer Identification	M	A – Primary Payer B – Secondary Payer C – Tertiary Payer MAPA – Enter MAPA to indicate Pennsylvania Medical Assistance.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
		A	Medicare or Medicare Advantage Plans – Enter 2 to indicate Medicare “A”, if applicable.
		A	Commercial Insurance – Enter 1 and the name of the insurance carrier to indicate commercial insurance, if applicable.
51	Health Plan ID	LB	Do not complete this Form Locator.
52	Release of Information	LB	Do not complete this Form Locator.
53	Assignment of Benefits	LB	Do not complete this Form Locator.
54 (A, B, C)	Prior Payments	LB	A – Primary Payer B – Secondary Payer C – Tertiary Payer MAPA – Do not complete this portion of this Form Locator.
		A	Commercial Insurance Paid – Enter the portion of the bill that was paid by another insurance company. Maintain a file copy of that insurance company’s Explanation of Benefits (EOB) Statement. Note: When another insurance is responsible for making full payment for the service provided, do not enter the payment amount in this Form Locator. However, the days <u>must</u> be included as non-covered days in Form Locators 39a through 41d.
		A	Medicare or Medicare Advantage Plans – Enter the total dollar amount that Medicare paid for the <u>coinsurance days</u> during the service month. Note: Do not include the amounts that Medicare approved and/or paid for the <u>full Medicare days</u> during the service month. <i>Only Positive Dollar Amounts Are To Be Entered For Any Payer And Patient When Billing MA.</i>
55	Estimated Amount Due	LB	Do not complete this Form Locator.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
56	NPI	M	Enter the 10-digit NPI number for the service provider.
57 (A, B, C)	Other Provider Number	M O O	<p>A – Primary Payer B – Secondary Payer C – Tertiary Payer</p> <p>MAPA – Enter the 9-digit provider number and 4-digit service location (e.g., 0342212210012).</p> <p>Commercial Insurance – Enter the provider number.</p> <p>Medicare or Medicare Advantage Plans – Enter the Medicare provider number.</p> <p>Do not use slashes, hyphens, or spaces.</p>
58 (A, B, C)	Insured's Names	LB A A	<p>A – Primary Payer B – Secondary Payer C – Tertiary Payer</p> <p>MAPA – Do not complete this portion of the Form Locator.</p> <p>Commercial Insurance – Enter the name of the person who holds other insurance coverage on the appropriate line.</p> <p>Medicare or Medicare Advantage Plans – Enter the name of the person who holds the policy on the appropriate line.</p>
59 (A, B, C)	Patient's Relationship to Insured	LB A A	<p>A – Primary Payer B – Secondary Payer C – Tertiary Payer</p> <p>MAPA – Do not complete this portion of the Form Locator.</p> <p>Commercial Insurance – Enter the code for the Patient's Relationship to the Insured on the appropriate line.</p> <p>Medicare or Medicare Advantage Plans – Enter the code for the Patient's Relationship to the Insured on the appropriate line.</p> <p><i>For a complete listing and description of Patient's Relationship to Insured, refer to the UB-04 Desk Reference for Long Term Care Facilities, located in Appendix A of the handbook.</i></p>

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
60 (A, B, C)	Insured's Unique ID	M A A	<p>A – Primary Payer</p> <p>B – Secondary Payer</p> <p>C – Tertiary Payer</p> <p>MAPA – Enter the 10-digit beneficiary identification number as shown on the MA ACCESS Card.</p> <p>Commercial Insurance – Enter the policy number for the insurance company.</p> <p>Medicare or Medicare Advantage Plans – Enter the resident's Medicare HIC number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form or as reported by the Social Security office.</p>
61 (A, B, C)	Insurance Group Name	LB A LB	<p>A – Primary Payer</p> <p>B – Secondary Payer</p> <p>C – Tertiary Payer</p> <p>MAPA – Do not complete this portion of the Form Locator.</p> <p>Commercial Insurance – Enter the name of the group or plan through which insurance has been obtained.</p> <p>Medicare or Medicare Advantage Plans – Do not complete this portion of the Form Locator.</p>
62 (A, B, C)	Insurance Group Number	LB A LB	<p>A – Primary Payer</p> <p>B – Secondary Payer</p> <p>C – Tertiary Payer</p> <p>MAPA – Do not complete this portion of the Form Locator.</p> <p>Commercial Insurance – Enter the insurance group number, which identifies the group in Form Locator 61.</p> <p>Medicare or Medicare Advantage Plans – Do not complete this portion of the Form Locator.</p>
63	Treatment Authorization Codes	LB	Do not complete this Form Locator.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
64 (A, B, C)	Document Control Number	LB LB A	<p>A – Primary Payer B – Secondary Payer C – Tertiary Payer</p> <p>Do not complete this portion of the Form Locator.</p> <p>Do not complete this portion of the Form Locator.</p> <p>When resubmitting denied claims, enter the original denied ICN number on the MAPA line of this Form Locator.</p> <p>For claim adjustments or voids, enter the ICN number of the last paid claim.</p>
65 (A, B, C)	Employer Name	LB A LB	<p>A – Primary Payer B – Secondary Payer C – Tertiary Payer</p> <p>MAPA – Do not complete this portion of the Form Locator.</p> <p>Commercial Insurance – Enter the name of the employer of the insured or possibly insured resident, spouse, parent or guardian identified in Form Locator 58.</p> <p>Medicare or Medicare Advantage Plans – Do not complete this portion of the Form Locator.</p>
66	DX-Version Qualifier	LB	Do not complete this Form Locator.
67 67A	Principle Diagnosis Code Other Diagnosis	M A	<p>For dates of discharge prior to October 1, 2015, enter up to five digits of the ICD-9-CM code for the principal diagnosis; OR for dates of discharge on or after October 1, 2015, enter up to seven digits of the ICD-10-CM code for the principal diagnosis.</p> <p><i>Do not use decimals.</i></p> <p>For dates of discharge prior to October 1, 2015, enter up to five digits of the ICD-9-CM code; OR for dates of discharge on or after October 1, 2015, enter up to seven digits of the ICD-10-CM code for diagnosis, other than the principal diagnosis, in field A.</p>

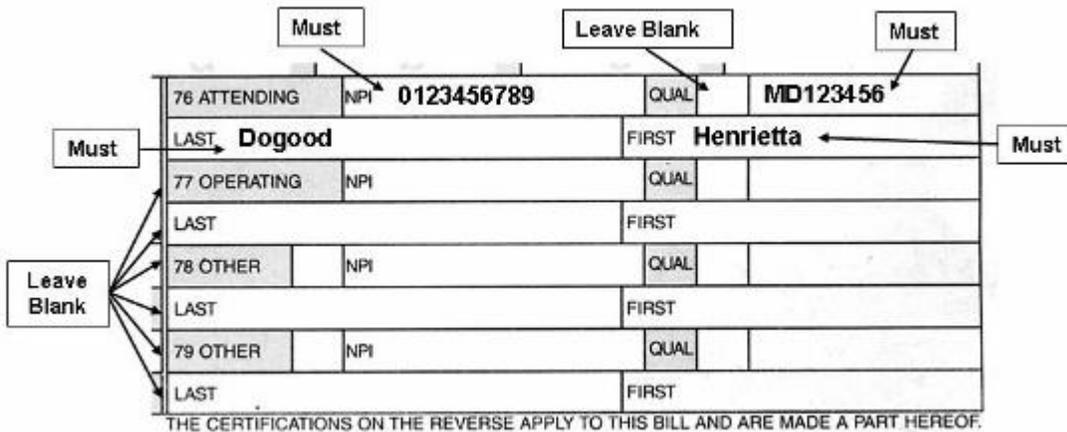
UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
B - Q		LB	<i>Do not use decimals.</i> Do not complete this portion of the Form Locator.
68	Unlabeled	LB	Do not complete this Form Locator.
69	Admitting Diagnosis Code	LB	Do not complete this Form Locator.
70 (A, B, C)	Patient's Reason for Visit Code	LB	Do not complete this Form Locator.
71	PPS Code	LB	Do not complete this Form Locator.
72 (A, B, C)	External Cause of Injury (ECI)	LB	Do not complete this Form Locator.
73	Unlabeled	LB	Do not complete this Form Locator.
74	Principle Procedure Code/Date	LB	Do not complete this portion of the Form Locator.
A-E	Other Procedure Code/Date	LB	Do not complete this portion of the Form Locator.
75	Unlabeled	LB	Do not complete this Form Locator.
76	Attending NPI	M	Enter the NPI number of the resident's attending physician in the first block of this Form Locator.
	Qual	LB	Do not complete this portion of the Form Locator.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
	ID (Unlabeled)	M	<p>Attending LTC providers are required to enter their license number. If a physician group is caring for the resident, enter the license number of the physician who treats the resident most often.</p> <p>Note: The license number should be entered with two alpha characters, six numeric characters, and one alpha character (e.g., MD011234L). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (e.g., MD123456).</p>
	Attending Name	M	Enter last name in first block and first name in the second block.

The following graphic shows Form Locators 76–79 with sample data and their requirements. Please refer to the detailed notes for each Form Locator for specific completion instructions.



77	Operating NPI/Qual/ID Other Name	LB	Do not complete this Form Locator.
78	Other ID NPI/Qual/ID Other Name	LB	Do not complete this Form Locator.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
79	Other ID NPI/Qual/ID Other Name	LB	Do not complete this Form Locator.
80	Remarks	A	<p>Non-Covered Medicare Stay:</p> <p>When submitting a claim for a non-covered Medicare stay, enter the reason for Medicare Non-Coverage in this Form Locator:</p> <ul style="list-style-type: none"> • No 3-Day Prior Hospital Stay; • Not Transferred Within 30 Days of Hospital Discharge; • 100 Benefit Days Exhausted; • No 60-Day Break in Daily Skilled Care; • Medical Necessity Requirements Not Met; • Daily Skilled Care Requirements Not Met. <p>Example: If there was no 3-day prior hospital stay, enter “No 3-day prior hospital stay”. For additional information on submitting a claim for Medicare Non-Coverage, see page 2 of this billing guide.</p> <p>This section may also be used if additional space is needed to explain unusual circumstances or conditions relative to services reported on the claim.</p> <p>This Form Locator can also be used for overflow from Form Locators 31a through 36b (e.g., hospitalization dates).</p> <p>Reason for Adjustment Code(s):</p> <p>When submitting an adjustment related to the ICN in Form Locator 64), enter the applicable adjustment reason code(s).</p> <ul style="list-style-type: none"> • 8001 Change the Patient Control Number • 8002 Change the Covered Dates • 8003 Change the Covered/Non-Covered Days • 8004 Change the Admission Dates/Time • 8005 Change the Discharge Times • 8006 Change the Status • 8007 Change the Medical Record Number • 8008 Change the Condition Codes (sometimes to make claim an “outlier” claim)

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Form Locator Number	Form Locator Name	Form Locator Code	Notes
			<ul style="list-style-type: none"> • 8009 Change the Occurrence Codes • 8010 Change the Value Codes • 8011 Change the Revenue Codes • 8012 Change the Units Billed • 8013 Change the Amount Billed • 8014 Change the Payer Codes • 8015 Change the Prior Payments • 8016 Change the Prior Authorization Number • 8017 Change the Diagnosis Codes • 8018 Change the ICDN Codes and Dates • 8019 Change the Physician ID Numbers • 8020 Change the Billed Date <p><i>For a complete listing of adjustment reason codes, refer to the UB-04 Desk Reference for Long Term Care Facilities, located in Appendix A of the handbook.</i></p> <p>Qualified Small Businesses</p> <p>Qualified small businesses must <u>always</u> enter the following message in Form Locator 80 (Remarks a, b, c, d) of the UB-04, in addition to any applicable attachment type codes or Medicare non-coverage:</p> <p>“(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.”</p>
81 CC (a,b,c,d)	Code-Code QUAL/CODE /VALUE	LB	Do not complete this Form Locator.

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Type of Bill Codes (Form Locator 4)
<p><u>First 2 Digits</u> 26 Nursing Facility 65 ICF/MR or ICF/ORC Facility</p> <p><u>Third Digit</u> 0 Non Payment/Zero Claim 1 Admit through Discharge Claim 2 Interim – First Claim 3 Interim – Continuing Claim 4 Interim – Last Claim 7 Replacement of Prior Claim 8 Void/Cancel of Prior Claim</p>
Patient Status Codes (Form Locator 17)
<p>01 Discharge to home or self-care – Routine Discharge 02 Discharged/transferred to another hospital for inpatient care 03 Discharged/transferred to Skilled Nursing Facility 04 Discharged/transferred to an Intermediate Care Facility 05 Discharged/transferred to another type of Institution for Inpatient Care 07 Left against medical advice or discontinued Care 20 Expired 30 Still a Patient</p>
Value Codes (Form Locators 39 – 41)
<p>23 Gross Patient Pay Amount 25 Drug Deductions 31 Lifetime Other Medical Expenses (related to facility services) 34 Other Medical Expenses 35 Health Insurance Premiums 66 Net Patient Pay Amount</p> <p>80 Covered Days 81 Non-covered Days 82 Coinsurance Day</p>

Condition Codes (Form Locators 18 – 28)
<p>02 Condition is Employment Related 03 Patient is Covered by Insurance Not Reflected Here 05 Lien Has Been Filed 77 Provider accepts or is obligated/required to a contractual agreement of law to accept payment by primary payer as payment in full X2 Medicare EOMB on File X4 Medicare Denial on File X5 Third Party Payment on File X6 Restricted Recipient Referral Form B3 Pregnancy Y6 Third Party Denial on File</p>
Admission Source Codes (Form Locator 15)
<p>1 Physician Referral 2 Clinic Referral 3 HMO Referral 4 Transfer from a Hospital 5 Transfer from a Skilled Nursing Facility 6 Transfer from Another Health Care Facility 7 Emergency Room 8 Court/Law Enforcement 9 Information Not Available A Transfer from a Critical Care Access Hospital</p>
Occurrence Codes (Form Locators 31 – 34)
<p>01 Auto Accident 02 No Fault Accident 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident 06 Crime Victim 24 Date Insurance Denied 25 Date Benefits Terminated by Primary Payer A3 Benefits Exhausted – Payor A B3 Benefits Exhausted – Payor B DR Disaster Related</p>

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

Revenue Codes (Form Locator 42)
0100 Facility Days 0183 Therapeutic Leave Days 0185 Hospital Reserve Bed Days
Patient's Relationship to Insured Codes (Form Locator 59)
18 Patient is Insured 19 Natural Child/Insured Financial Responsibility 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Minor Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Natural Child/Insured does not have Financial Responsibility 53 Life Partner G8 Other Relationship Please note that the Patient's Relationship to Insured Codes are the same codes used electronically in the 837I.
Medicare Non-Coverage Reasons (Form Locator 80)
<ul style="list-style-type: none"> ○ No 3-Day Prior Hospital Stay ○ Not Transferred Within 30 Days of Hospital Discharge ○ 100 Benefit Days Exhausted ○ No 60-Day Break in Daily Skilled Care ○ Medical Necessity Requirements Not Met ○ Daily Skilled Care Requirements Not Met

Occurrence Span Codes (Form Locators 35 – 36)
74 Non-Covered Level of Care/Leave of Absence (Inpatient Hospital Stay) MR Disaster Related
Reason for Adjustment Codes (Form Locator 80)
8001 Change the Patient Control Number 8002 Change the Covered Dates 8003 Change the Covered/Non-Covered Days 8004 Change the Admission Dates/Times 8005 Change Discharge Times 8006 Change the Status 8007 Change the Medical Record Number 8008 Change the Condition Codes (sometimes to make claim an 'outlier' claim) 8009 Change the Occurrence Codes 8010 Change the Value Codes 8011 Change the Revenue Codes 8012 change the Units Billed 8013 Change the Amount Billed 8014 Change the Payer Codes 8015 Change the Prior Payments 8016 Change the Prior Authorization Number 8017 Change the Diagnosis Codes 8018 Change the ICDN Codes and Dates 8019 Change the Physician ID Numbers 8020 Change the Billed Date

UB-04 Claim Form Completion for PROMISe™ ICF/MR, ICF/ORCs and State MR Centers

180-Day Exception Request Detail Page For Long Term Care Facilities

1. Facility Name: _____

2. Provider Type/MAID: _____

3. Resident Name: _____

4. Dates of Service: _____

5. 180-Day Exception is being requested due to:

A. Delay in eligibility determination by CAO:

1. Date of request for MA eligibility determination _____

2. Date of eligibility notification..... _____

B. Delay in processing third party statement/denial:

1. Date payment was requested from third party.... _____

2. Date of payment/denial from third party..... _____

C. UMR Financial Review-change in income.

D. Other _____

NOTE: Please attach all documentation applicable to the dates indicated under number 5.

Date: _____

Before sending your exception request, did you remember to:

- ❖ Enclose a correct, original and completed invoice (File or photocopies will **NOT** be accepted)?
- ❖ Enclose a signed signature transmittal (MA 307) **dated 11/06**?
- ❖ Enclose all applicable documentation?

Attention: OLTL Inquiry Unit

Department of Public Welfare
Office of Long Term Living
Division of Provider Services
P.O. Box 8025
Harrisburg, PA 17105