

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

UB-04 Completion: Inpatient Services Billing Example

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The example in this section is to help providers bill inpatient services on the *UB-04* claim. Refer to the *UB-04 Completion: Inpatient Services* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual. Hospitals reimbursed according to the diagnosis-related groups (DRG) reimbursement method should also refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Remarks* field (Box 80) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Surgical Pediatric Patient

Figure 1. Three-day stay for a surgical pediatric patient.

This is a sample only. Please adapt to your billing situation.

In this case, a 6-year-old boy is admitted on August 7, 2013, with a broken tibia and fibula. The boy is admitted to the hospital through the emergency room and an operation is performed. After the surgery, the boy enters the recovery room and is later admitted to the pediatric ward. He is released from the hospital on August 10.

Enter the two-digit facility type code "11" (hospital – inpatient) and one-character claim frequency code "1" as "111" in the *Type of Bill* field (Box 4).

Enter the date of admission, August 7, as 080713 in the *Admission Date* field (Box 12). Enter the 7 p.m. hour of admission in military terms (19) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14), enter the "type" of admission. In this case, the "1" indicates an emergency admit.

The total length of stay is entered in the *Statement Covers Period* field (Box 6). Enter the dates (080713 and 081013) in six-digit format. The day of admission is entered as the "From" date and the day of discharge is entered as the "Through" date. Enter the hour of discharge in military time (11) in the *Discharge Hour* field (Box 16) and the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the boy was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 – 24). Condition Code "YO" indicates the recipient is under 65 and does not have Medicare coverage.

Enter the appropriate revenue codes and descriptors in the *Revenue Code* and *Description* fields (Boxes 42 and 43). All ancillary services are listed. Ancillary services are not separately reimbursable for all hospitals. Units of service are not required for ancillary services.

Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter code 001 in the *Revenue Code* column (Box 42) to designate the total charge line.

Enter the *Treatment Authorization Request* (TAR) control number in the *Treatment Authorization Codes* field (Box 63). In this case, TAR approval is required for the boy's entire stay.

Enter an appropriate ICD-9-CM diagnosis code in Box 67. In this case, ICD-9-CM code 823.22 represents fractures of both the tibia and fibula, shaft closed, and is entered on the claim as 82322.

Note: Hospitals reimbursed according to the DRG payment method are encouraged to enter all applicable diagnosis codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level.

Hospitals also, must enter a present on admission (POA) indicator, if required, in the shaded area to the right of each diagnosis code. In this example, diagnosis code 823.22 would require a "Y" (yes) indicator because the leg fractures were present on admission.

Enter the principal ICD-9-CM Volume 3 procedure code 79.06 (closed reduction of fracture without internal fixation, tibia and fibula) in the *Principal Procedure* field (Box 74) as 7906. The date the procedure was performed, August 7, 2013, is entered as 080713 adjacent to the procedure.

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

Enter the attending physician's NPI in the *Attending* field (Box 76).
Enter the operating physician's NPI in the *Operating* field (Box 77).
Enter the admitting physician's NPI in the *Other* field (Box 78).

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1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT CNTL # b MED REC #		4 TYPE OF BILL 111	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
080713				081013			
8 PATIENT NAME a				9 PATIENT ADDRESS a			
b DOE JOHN							
10 BIRTHDATE 04242007		11 SEX M		12 DATE OF ADMISSION 080713		13 TYPE OF ADMISSION 19	
14 SRC		15 SRC		16 DHR		17 STAT	
11		01		YO			
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE	
35 CODE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38	
39 VALUE CODES CODE		40 VALUE CODES AMOUNT		41 VALUE CODES CODE		42 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1 123		ROOM AND BOARD				46 SERV. UNITS	
2 250		GENERAL PHARMACY				3	
3 272		STERILE SURGICAL SUPPLIES				114000	
4 300		GENERAL LABORATORY				11096	
5 320		DIAGNOSTIC RADIOLOGY, GEN				16181	
6 360		OPERATING RM. SERVICES, GEN				5004	
7 370		ANESTHESIA, GEN				88033	
8 410		RESPIRATORY SERVICES, GEN				64000	
9 420		PHYSICAL THERAPY, GEN				25083	
10 450		EMERGENCY ROOM, GEN				464	
11 710		RECOVERY ROOM, GEN				39000	
						5000	
						10200	
23 001		PAGE OF		CREATION DATE		TOTALS	
						378061	
50 PAYER NAME A I/P MEDI-CAL		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
B							
C							
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		0123456789	
		378061		57 OTHER PRV ID			
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A				90000000A95001			
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 01234567890							
B							
C							
68 DX 82322 Y		69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
A		a		b		c	
B							
C							
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		QUAL	
A 7906		080713		1234567890			
B				LAST		FIRST	
C							
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		QUAL	
A 2345678901		3456789012					
B		LAST		FIRST			
C							
80 REMARKS		81 CC a		82 CC b		83 CC c	
A		a		b		c	
B							
C							
84		85		86		87	
UB-04 CMS-1450 © 2005 NUBC		OMB APPROVAL PENDING		NUBC LIC9213257		THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.	

Figure 1. Three-Day Stay for a Surgical Pediatric Patient .