

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

UB-04 Tips for Billing: Inpatient Services

This section describes *UB-04* claim fields that must be completed accurately and completely in order to avoid claim suspense or denial. Tips below are designed to supplement instructions in the *UB-04 Completion: Inpatient Services* section of this manual.

Common Billing Errors

Field	Description	Error
<u>18 – 24</u>	Condition Codes	<p>Omitting codes or entering a Medi-Cal local billing limit exception code (X0, X1 – X9).</p> <p>Billing Tip: The delay reason code is entered in Box 37A of the claim.</p> <p>Enter codes in numeric-alpha order. For example, 80, 82, A1.</p>
39 – 41 A – D	Value Codes and Amount (Patient’s Share of Cost)	<p>Missing value code information. Entering only the value code and not the amount. Entering only the amount and not the value code.</p> <p>Billing Tip: Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence, starting with the lowest level. Value code information is required for Medicare/Medi-Cal crossovers.</p>
50 A – C	Payer Name	<p>Missing all payer information.</p> <p>Billing Tip: Be sure to enter the “I/P” indicator.</p>
54 A – B	Prior Payments (Other Coverage)	<p>Missing prior payment or Other Health Coverage not indicated.</p> <p>Billing Tip: Be sure to enter the patient’s other health insurance payment. Do not enter Medicare payments in this box.</p>
<u>56</u>	<u>NPI</u>	<p>Missing or incorrect NPI number.</p> <p>Billing Tip: Enter the <u>NPI</u>.</p>
60 A – C	<u>Insured’s Unique ID</u>	<p>Entering the recipient Medi-Cal ID number incorrectly.</p> <p>Billing Tip: Verify that the recipient is eligible for the services rendered by using the POS network or telephone AEVS. Do not enter the Medicare ID number.</p>

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Field	Description	Error
63 A – C	Treatment Authorization Codes	Entering EVC number instead of the TAR number. Billing Tip: The EVC number is only for verifying eligibility and should not be entered on the claim.
<u>74 – 74E</u>	<u>Principal/Other Procedure Codes and Dates</u>	Missing or incorrect ICD-9-CM Volume 3 procedure code, or a CPT-4/HCPCS procedure code entered. Billing Tip: Inpatient providers place ICD-9-CM Volume 3 procedure codes instead of CPT-4/HCPCS surgical procedure codes in this field. <u>Billing Tip: Hospitals paid according to the diagnosis-related groups (DRG) reimbursement methodology are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the <i>Principal/Other Procedure</i> fields so the claim will reimburse at the appropriate level.</u>
76	Attending Physician ID	Missing or incorrect attending physician's NPI number. Billing Tip: Do not enter the operating or admitting physician's NPI in this field.
77	Operating Physician ID	Missing or incorrect operating physician's NPI number.
78	Other Physician ID	For Inpatient provider use only: Missing or incorrect admitting physician's NPI.
80	Remarks	Reducing font size or abbreviating terminology to fit in the field. Billing Tip: If additional information cannot be completely entered in this field, attach the additional information to the claim. Reducing the font size and abbreviating terminology may result in scanning difficulties and/or medical review denials.

Field Completion Reminders

Providers should remember the following when completing the claim form.

- Submit separate claims for inpatient services. Do not combine inpatient and outpatient services on the same claim.
- For hospitals paid according to the diagnosis-related groups (DRG) reimbursement methodology, claims for services rendered to newborns must be billed separately from the mother's claim.
- Enter the hospital name. Enter the address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen in the upper left hand corner of the form (Box 1). A telephone number is optional in this field.

Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.

- Box 2 is reserved for the Department of Health Care Services (DHCS) Fiscal Intermediary (FI) use only. Type only in areas of the form designated as fields. Do not type in undesignated white space.
- Enter the three-digit type of bill code (comprised of two-digit facility type and one character claim frequency code) in the *Type of Bill* field (Box 4).
- To strike out a claim line with incorrect information, draw a line through the entire detail line from the left border of *Revenue Code* field (Box 42) to the right border of the *Unlabeled* field (Box 49). Enter the correct billing information on another detail line. Be sure to use only a blue or black ballpoint pen. Felt-tip pens are unacceptable.
- Include the individual dates of service after entering a description of services rendered in the *Description* field (Box 43) for "from-through" billing.
- Enter "001" (Total Charges) in field 42, line 23, and enter the total amount in field 47, line 23.
- Enter the NPI number in the *NPI* field (Box 56).

Paper Claim Form Requirements

The following paper claim form requirements and standard billing procedures can speed claim processing and prevent delays. Before submitting claims, check to see that:

- The *UB-04* claim is printed with “drop-out” ink and that the form meets National Uniform Billing Committee (NUBC) standards.
- The original claim is submitted. Carbon copies, photocopies, computer-generated claim form facsimiles, or claim forms created on laser printers are not acceptable.
- Individual claim forms are separated. Each claim is processed separately. Do not staple individual claims together. Stapling individual claims together indicates the second claim is an “attachment,” not an original claim to be processed separately.
- Claims submitted for DRG-reimbursed hospitals that are longer than one page must ensure the following information appears on all pages and is identical on each page: the provider number, recipient identification number, dates of admission and all diagnosis and procedure codes.
- All perforated sides are removed. For accurate scanning, be sure to leave a ¼-inch border on the left and right side of the form after removing the perforated sides.
- Information is typed within the designated area of the field. Ensure the type falls completely within the text space and is properly aligned with corresponding information. If using a DOT matrix printer, do not use “draft mode.” The characters do not have enough distinction and clarity for the optical character reader to accurately determine the contents.
- All dates are entered without slashes. Do not use punctuation, such as a decimal point (.), dollar sign (\$), positive (+) or negative (-) symbol when entering amounts.
- Attachments are taped to an 8½ x 11-inch sheet of paper with non-glare tape. Do not use original claims as attachments.