

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

## Obstetrics: UB-04 Billing Examples for Inpatient Services – DRG Payment Method

ob ub ex drg

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Examples in this section are to help providers submit obstetric (OB) and newborn inpatient services claims with adequate detail so claims reimburse at the appropriate level under the diagnosis-related groups (DRG) payment methodology.

Refer to the *Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals* section of this manual for detailed policy information. 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.

**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. In addition, for claims that will be reimbursed under the DRG payment methodology:

- The primary reason for admission should be placed in the primary diagnosis field (Box 67) of the *UB-04* claim form.
- The newborn claim must be submitted independently of the mother's claim for delivery. A claim submitted with both delivery and neonatal services together will be denied.
- Providers must ensure that interim claims (claims exceeding 29 days) submitted on various dates contain consistent Benefits Identification Card (BIC) numbers. The newborn's unique Medi-Cal BIC number is preferred on claims for the newborn, but the mother's BIC number is acceptable. Interim claims for the same neonatal stay with both the newborn's and mother's number, or numbers that disagree with the previous interim claim, will be denied.

### Electronic Claims: Baby Using Mother's ID Number

For electronic claim submissions, a statement indicating "baby using mother's ID" must be entered in the NTE segment of the 837I v.5010 electronic claim.

**Cesarean Delivery of  
Acutely Sick Newborn:  
DRG-Reimbursed Hospital**

*Figures 1a and 1b. Cesarean delivery of acutely sick newborn.  
Diagnosis-related groups (DRG)-reimbursed hospital.*

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

**Case Description**

A mother, who was admitted on August 1, delivers an acutely sick newborn by cesarean section on August 2. The baby develops tachycardia on August 2. The newborn is jaundiced and has a fever. Blood cultures are drawn and I.V. antibiotics are started. The newborn is given phototherapy. The mother is discharged August 5 and the baby is discharged August 8.

**Overview of Policy**

Because the newborn is ill, his hospital stays requires an admission *Treatment Authorization Request* (TAR). Services for the acutely sick baby are separately reimbursable and must be billed on a claim separate from the mother's claim.

**Mother's Claim**

*Figure 1a: Mother's claim.*

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

Enter the date of the mother's admission, August 1, 2013, in six-digit format (080113) in the *Admission Date* field (Box 12). Enter the 4 p.m. hour of admission in military terms (16) 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 the mother's stay is entered in the *Statement Covers Period* field (Box 6). Enter the day of admission (080113) as the "From" date and the day of discharge (080513) as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 11 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the mother was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 – 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

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Revenue code 152 is entered in the *Revenue Code* field (Box 42) to bill OB-related room and board services for the mother. Enter the description of code 152 (room and board, ward, OB) in the *Description* field (Box 43). Enter a 4 in the *Service Units* field (Box 46) to indicate the number of days the mother stayed in the hospital. Do not count the day of discharge.

All ancillary services are listed. 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, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Enter the appropriate primary diagnosis code in Box 67. In this case, ICD-9-CM diagnosis code V27.0 representing single live newborn is entered in primary diagnosis field Box 67 without decimal points. Secondary ICD-9-CM diagnosis code 669.71, (cesarean delivery, delivered with or without mention of antepartum condition) is entered as well:

**Note:** Hospitals reimbursed under 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.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, diagnosis code V27.0 is exempt from POA reporting requirements so no POA indicator is present. Because no illness was detected when the mother was admitted, the POA indicator "N" (no) is entered for diagnosis code 669.71.

Enter the principal ICD-9-CM Volume 3 procedure code 74.1 (low cervical cesarean section) in the *Principal Procedure* field (Box 74) as 741.

The date the procedure was performed, August 2, 2013, is entered as 080213 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 first *Other* field (Box 78).

#### Acutely Sick Newborn's Claim

*Figure 1b: Acutely sick newborn's claim.*

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

Enter the date of delivery, August 2, 2013, in six-digit format (080213) as the date of admission for the newborn in the *Admission Date* field (Box 12). Enter the newborn's noon hour of birth as the hour of admission in military terms (12) 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 length of time the baby stays at the hospital is entered in the *Statement Covers Period* field (Box 6). The date of the baby's admission (080213) is entered as the "From" date and the day of the baby's discharge (080813) is entered as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 10 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this scenario, the "01" indicates the baby was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 – 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

The sick-newborn services rendered require an approved TAR and are billed with revenue code 172. Enter code 172 in the *Revenue Code* field (Box 42) and the description of code 172 (nursery newborn, Level II) in the *Description* field (Box 43). Enter a 6 in the *Service Units* field (Box 46) to indicate billing six hospital days for the baby. The day of discharge is not reimbursable.

**Note:** Reimbursement for acute care days billed with revenue code 172 begins the day of the newborn's admission. This claim bills for services rendered to the sick newborn beginning August 2.

All ancillary services are listed. 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, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Type the mother's name (the insured party) in the *Insured's Name* field (Box 58). Enter code 03 in the *Patient's Relationship to Insured* field (Box 59) to designate that the recipient is the insured's child who is using his mother's ID number, which is entered in Box 60.

Enter the entire 11-digit TAR control number in the *Treatment Authorization Codes* field (Box 63). Code 172 services rendered to an acutely sick newborn require an admission TAR.

Enter the appropriate primary diagnosis code(s) in Box 67. In this case, ICD-9-CM diagnosis code V30.01 represents a single liveborn baby born in a hospital, delivered by cesarean section and is entered on the claim as V3001. The secondary diagnosis code, 771.83, represents bacteremia of newborn and is listed on the claim as 77183. Add the other applicable secondary diagnosis codes:

768.3: Fetal distress first noted during labor and delivery, in liveborn infant

774.6: Unspecified fetal and neonatal jaundice

765.29: 37 or more weeks of gestation

**Note:** Claims submitted for services rendered to a newborn require at least one diagnosis code. Hospitals reimbursed under 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. The primary diagnosis should be the appropriate V30.00 – V39.21 code for the birth episode.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, V30.01 is exempt from POA reporting. The baby's other conditions present at birth are considered to be present on admission and require a "Y" (yes) POA.

Procedures were also performed on the newborn. ICD-9-CM Volume 3 procedure code 99.21, which represents injection of an antibiotic, is entered in the *Principle Procedure* field (Box 74) as 9921. The other applicable secondary procedure codes are added and the date of each procedure is entered adjacent to the code in six-digit format.

90.53: Microscopic examination of blood

99.83: Other phototherapy

38.93: Venous catheterization

88.31: Skeletal series

**Note:** No procedure code related to the services rendered to the mother should appear on the newborn's claim. 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 first *Other* field (Box 78).

1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555										2	3a PAT CNTL #	3b MED REC #	4 TYPE OF BILL	111																	
												5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH	080113	080513																
8 PATIENT NAME	a	9 PATIENT ADDRESS	a	b	DOE JANE	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z			
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACCT STATE	30	31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37	
		08241986	F	080113	16	1	11	01	YO																							
38	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT	42	REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49																	
									152 ROOM & BOARD, WARD, OB			4	360000																			
									250 GENERAL PHARMACY				11025																			
									300 GENERAL LABORATORY				49375																			
									720 LABOR ROOM/DELIVERY GEN.				64000																			
									710 RECOVERY ROOM GENERAL				43500																			

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1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2	3a PAT CNTL # 3b MED REC #	4 TYPE OF BILL 111
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 080213	7 THROUGH 080813		
8 PATIENT NAME a	9 PATIENT ADDRESS a	b	c	d
10 BIRTHDATE 08022013	11 SEX M	12 DATE OF ADMISSION 080213	13 HR 12	14 TYPE 1
15 SRC 10	16 DHR 01	17 STAT YO	18	19
20	21	22	23	24
25	26	27	28	29 ACCT STATE 30
31 OCCURRENCE DATE CODE	32 OCCURRENCE DATE CODE	33 OCCURRENCE DATE CODE	34 OCCURRENCE DATE CODE	35 CODE
36 OCCURRENCE SPAN FROM	37 THROUGH	38 CODE	39 OCCURRENCE SPAN FROM	40 THROUGH
41 CODE	42 VALUE CODES AMOUNT	43 CODE	44 VALUE CODES AMOUNT	45 CODE
46 VALUE CODES AMOUNT	47 CODE	48 VALUE CODES AMOUNT	49 CODE	50 VALUE CODES AMOUNT
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS
47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	50	51
1	172 NURSERY NEWBORN, LEVEL II			6
2	300 GENERAL LABORATORY			65000
3	370 ANESTHESIA, GENERAL			29395
4	410 RESPIRATORY SVCS.			50505
5	710 RECOVERY ROOM, GENERAL			31694
6				40006
7				
8				
9				
10				
11				
12				
13				
14				
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23	001 PAGE OF	CREATION DATE	TOTALS	216600
50 PAYER NAME I/P MEDI-CAL	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS
55 EST. AMOUNT DUE 216600	56 NPI 0123456789	57 OTHER PRV ID	58 INSURED'S NAME JANE DOE	59 PREL 03
60 INSURED'S UNIQUE ID 90000000A95001	61 GROUP NAME	62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES 01234567890	64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME	66	67	68	69
70 ADMIT DX V3001	71 PATIENT REASON DX 77183	72	73	74
75	76 ATTENDING NPI 1234567890	77 QUAL	78 LAST	79 FIRST
80	77 OPERATING NPI 2345678901	78 QUAL	79 LAST	80 FIRST
81	78 OTHER NPI 3456789012	79 QUAL	80 LAST	81 FIRST
82	79 OTHER NPI	80 QUAL	81 LAST	82 FIRST
83	80 REMARKS	81 CC a	82	83
84	81 CC b	82	83	84
85	81 CC c	82	83	84
86	81 CC d	82	83	84

Figure 1b. Cesarean Delivery. Acutely Sick Newborn's Claim. DRG-Reimbursed Hospital.

**Multiple Births of  
Twins with Differing  
Dates of Birth:  
DRG-Reimbursed Hospital**

*Figures 2a, 2b and 2c. Multiple births of twins with differing dates of birth. Diagnosis-related groups (DRG)-reimbursed hospital.*

*These are samples only. Please adapt to your billing situation.*

Case Description

A mother, who is admitted on August 1, delivers her first twin (well newborn) vaginally on August 2 and her second twin (sick newborn) vaginally on August 3. The mother and her well newborn twin are discharged on August 5. The sick newborn twin is discharged on August 8.

Overview of Policy

The mother's hospital stay and services for the healthy twin do not require TARs. The second twin is admitted to the Neonatal Intensive Care Unit (NICU) and requires an approved admit TAR for services commencing with the date of admission. Separate claims are required for each patient: the mother, the healthy twin and the sick twin.

**Note:** *Welfare and Institutions Code (W&I Code), Section 14132.42 prohibits hospitals from discharging a mother before 48 hours following a normal vaginal delivery, unless early discharge is agreed upon by both the treating physician and the mother. If the mother is discharged early, a post-discharge follow-up visit must be made available to the mother and her newborn within 48 hours of discharge.*

Mother's Claim

*Figure 2a: Mother's claim.*

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

Enter the date of the mother's admission, August 1, 2013, in six-digit format (080113) in the *Admission Date* field (Box 12). Enter the 9 p.m. hour of admission in military terms (21) 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 the mother's stay is entered in the *Statement Covers Period* field (Box 6). Enter the day of admission (080113) as the "From" date and the day of discharge (080513) as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 11 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the mother was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 – 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 152 is entered in the *Revenue Code* field (Box 42) to bill OB-related room and board services for the mother. Enter the description of code 152 (room and board, ward, OB) in the *Description* field (Box 43). Enter a 4 in the *Service Units* field (Box 46) to indicate the number of days the mother stayed in the hospital. Do not count the day of discharge.

All ancillary services are listed. 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, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Enter an appropriate primary diagnosis code in Box 67. In this case, ICD-9-CM diagnosis code 651.01 represents a twin pregnancy. Code V27.2 indicates twins, both liveborn. The codes are entered on the claim as 65101 and V272 respectively.

**Note:** Hospitals reimbursed under 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.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, diagnosis code 651.01 indicates the mother was carrying twins on admission and requires a "Y" (yes) POA. Diagnosis code V27.2 is exempt from POA reporting so no POA indicator is present.

ICD-9-CM Volume 3 procedure code 72.0 (low forceps operation) is entered in the *Principal Procedure* field (Box 74). Also included is ICD-9-CM Volume 3 procedure code 75.69 (repair of other current obstetric laceration). They are entered respectively on the claim as 720 and 7569. The date of the procedure, August 2, 2013, is entered as 080213 adjacent to both procedure codes.

**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.

When billing claims involving multiple births, the multiple births and specific birth date for each newborn should be included in the *Remarks* field (Box 80).

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 first *Other* field (78).

## Healthy Twin's Claim

*Figure 2b: Healthy Twin's Claim.*

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

Enter the date of the first healthy twin's delivery, August 2, 2013, in six-digit format (080213) as the date of admission in the *Admission Date* field (Box 12). Enter the twin's 11 p.m. hour of birth as the hour of admission in military terms (23) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "4" indicates a newborn admit.

The length of time the baby stays in the hospital is entered in the *Statement Covers Period* field (Box 6). The day of birth (080213) is entered as the "From" date and the day of discharge (080513) is entered as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is noon (12). Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this scenario, the "01" indicates the baby was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 – 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 171 is entered in the *Revenue Code* field (Box 42) and the description of code 171 (nursery newborn, Level I) in the *Description* field (Box 43). Enter a 3 in the *Service Units* field (Box 46) to indicate number of days the baby stayed in the hospital. Do not include the day of discharge.

All ancillary services are listed. 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, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Type the mother's name (the insured party) in the *Insured's Name* field (Box 58). Enter code 03 in the *Patient's Relationship to Insured* field (Box 59) to designate that the recipient is the insured's child who is using his mother's ID number, which is entered in Box 60.

Enter an appropriate primary ICD-9-CM code in Box 67. In this case, code V33.00 represents an unspecified twin, born in a hospital and delivered without mention of cesarean delivery. ICD-9-CM diagnosis code 765.29 represents gestation age of a single live newborn at more than 37 weeks of age. The codes are entered on the claim as V3300 and 76529, respectively.

**Note:** Claims submitted for services rendered to a baby require at least one diagnosis code. Hospitals reimbursed under 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. The primary diagnosis should be the appropriate V30.00 – V39.21 code for the birth episode.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, V33.00 is exempt from POA reporting requirements. For code 765.29, the twin is healthy so the POA indicator is an "N" (no).

No procedures were performed on the newborn, so no procedure code is required.

**Note:** No procedure code related to the services rendered to the mother should appear on the baby's claim. 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.

When billing claims involving multiple births, the multiple births and the specific birth dates for both twins are included in the *Remarks* field (Box 80) on both twins' claims.

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 first *Other* field (Box 78).

## NICU-Admitted Twin's Claim

*Figure 2c: Second twin's claim (sick newborn requiring NICU services).*

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

Enter the date of the second twin's delivery, August 3, 2013, in six-digit format (080313) as the date of admission in the *Admission Date* field (Box 12). Enter the twin's 1 a.m. hour of birth as the hour of admission in military terms (1) 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 length of time the baby stays in the hospital is entered in the *Statement Covers Period* field (Box 6). The day of birth (080313) is entered as the "From" date and the day of discharge (080813) is entered as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 3 p.m. (15). Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this scenario, the "01" indicates the baby was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 – 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

The NICU services for the second twin must be billed using revenue code 174 on a claim separate from the mother. Enter code 174 in the *Revenue Code* field (Box 42) and the description of code 174 (nursery newborn; Level IV) in the *Description* field (Box 43). Enter a 5 in the *Service Units* field (Box 46) to indicate five days of NICU care. Do not include the day of discharge.

All ancillary services are listed. 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, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Type the mother's name (the insured party) in the *Insured's Name* field (Box 58). Enter code 03 in the *Patient's Relationship to Insured* field (Box 59) to designate that the recipient is the insured's child who is using his mother's ID number, which is entered in Box 60.

Enter the entire 11-digit TAR control number in the *Treatment Authorization Codes* field (Box 63). NICU services require an approved admit TAR for reimbursement of the days being billed, commencing with the date of admission.

Enter an appropriate primary ICD-9-CM code in Box 67. In this case, code V33.00 represents an unspecified twin, born in a hospital and delivered without mention of cesarean delivery. Code 765.29 represents gestation age of a single live newborn at more than 37 weeks of age. The codes are entered on the claim as V3300 and 76529, respectively.

Code 767.9 represents unspecified birth trauma for the newborn, code 759.0 represents aberrant spleen and code 426.6 represents intraventricular block. Enter without decimal points as 7679, 7590 and 4266 respectively.

**Note:** Claims submitted for services rendered to a newborn require at least one diagnosis code. Hospitals reimbursed under 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. The primary diagnosis should be the appropriate V30.00 – V39.21 code for the birth episode.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. Codes V33.00 and 759.0 are exempt from POA reporting requirements. All other diagnosis codes listed require a “Y” (yes) POA.

Enter ICD-9-CM Volume 3 procedure code 89.13 (neurologic examination) as 8913 in the *Principal Procedure* field (Box 74). Also enter Volume 3 procedure code 99.83 (other phototherapy) as 9983. The date of the procedure is listed in six-digit format adjacent to each procedure. In this example the procedures were performed on 080313.

**Note:** No procedure code related to the services rendered to the mother should appear on the baby’s claim. 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.

When billing claims involving multiple births, the multiple births and the specific birth dates for both twins are included in the *Remarks* field (Box 80) on both twins’ claims.

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 first *Other* field (Box 78).

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3 PAT CNTL # B MED REC #		4 TYPE OF BILL 111	
5 FED. TAX NO.				6 STATEMENT PERIOD FROM 080113		7 THROUGH 080513	
8 PATIENT NAME a		9 PATIENT ADDRESS a					
b DOE JANE							
10 BIRTHDATE		11 SEX F		12 DATE 080113		13 ADMISSION 13 IPR 14 TYPE 21	
15 SRC 1		16 DHR 11		17 STAT 01		18 YO	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 CODE		37 CODE		38 CODE	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT	
a		b		c		d	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	152	ROOM & BOARD, WARD, OB			4	280000	
2	250	GENERAL PHARMACY				11025	
3	300	GENERAL LABORATORY				49375	
4	720	LABOR ROOM/DELIVERY GEN.				64000	
5	710	RECOVERY ROOM GENERAL				43500	
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23	001	PAGE OF	CREATION DATE	TOTALS		447900	
50 PAYER NAME I/P MEDI-CAL		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 447900		56 NPI 0123456789		57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 65101 Y V272		70 PATIENT REASON DX		71 FPS CODE		72 ECI	
73		74 PRINCIPAL PROCEDURE DATE 080213		75 OTHER PROCEDURE DATE 080213		76 ATTENDING NPI 1234567890	
77 OPERATING NPI 2345678901		78 OTHER NPI 3456789012		79 OTHER NPI		80 REMARKS	
81 CC a		81 CC b		81 CC c		81 CC d	
82		83		84		85	
86		87		88		89	
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1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT CNTRL # b MED REC #		4 TYPE OF BILL 111	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM 080213		7 THROUGH 080513	
8 PATIENT NAME a DOE BABY				9 PATIENT ADDRESS a			
10 BIRTHDATE 08022013		11 SEX M	12 DATE 080213		13 HR 23	14 TYPE 4	15 SRC 12
16 DHR 01		17 STAT YO		18-21			
31 OCCURRENCE DATE 08022013		32 OCCURRENCE DATE 080213		33 OCCURRENCE DATE 080213		34 OCCURRENCE DATE 080213	
35 CODE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH		38	
39 CODE		40 VALUE CODES AMOUNT		41 CODE		42 VALUE CODES AMOUNT	
43 DESCRIPTION 1 171 NURSERY NEWBORN, LEVEL I 2 300 GENERAL LABORATORY		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS 3	
47 TOTAL CHARGES 60000		48 NON-COVERED CHARGES 20300		49		50	
51		52		53		54	
55		56		57		58	
59		60		61		62	
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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 080313		7 THROUGH 080813	
8 PATIENT NAME a DOE BABY				9 PATIENT ADDRESS a			
10 BIRTHDATE 08032013		11 SEX M	12 DATE 080313		13 HR	14 TYPE 1	15 SRC 1
16 DHR 15	17 STAT 01	18	19	20	21	22	23
31 OCCURRENCE DATE 08032013		32 OCCURRENCE DATE 080313		33 OCCURRENCE DATE 1		34 OCCURRENCE DATE 15	
35 CODE YO		36 OCCURRENCE SPAN FROM 080313		37 OCCURRENCE SPAN THROUGH 080813		38	
39 VALUE CODES CODE a		40 VALUE CODES AMOUNT b		41 VALUE CODES CODE c		42 VALUE CODES AMOUNT d	
42 REV. CD. 174		43 DESCRIPTION NURSERY NEWBORN, LEVEL IV		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
250		GENERAL PHARMACY				46 SERV. UNITS 5	
270		MEDICAL/SURGICAL SUPPLIES				47 TOTAL CHARGES 3216000	
300		GENERAL LABORATORY				48 NON-COVERED CHARGES 300000	
320		GENERAL LABORATORY				150025	
320		BLOOD GENERAL				40000	
320		RESPIRATORY SERVICES				100075	
						20000	
						30000	
001		PAGE OF		CREATION DATE		TOTALS 3856100	
50 PAYER NAME I/P MEDI-CAL		51 HEALTH PLAN ID		52 REL INFO		53 ASG SIGN	
						54 PRIOR PAYMENTS	
						55 EST. AMOUNT DUE 3856100	
						56 NPI 0123456789	
58 INSURED'S NAME JANE DOE		59 P.REL 03		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
						62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES 01234567890		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 DX V3300		76529	Y7679	Y7590	4266	Y	E N F G H
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 EQ	
74 PRINCIPAL PROCEDURE CODE 8913		75 OTHER PROCEDURE CODE 080313		76 ATTENDING NPI 1234567890		77 QUAL	
74 PRINCIPAL PROCEDURE DATE 080313		75 OTHER PROCEDURE DATE 080313		76 ATTENDING NPI 2345678901		77 QUAL	
74 PRINCIPAL PROCEDURE DATE 080313		75 OTHER PROCEDURE DATE 080313		76 ATTENDING NPI 3456789012		77 QUAL	
80 REMARKS MULTIPLE BIRTHS: NEWBORN#1 DEL 080213 WELL BABY NEWBORN#2 DEL 080313 SICK BABY		81 CC a		82		83	
		b		c		d	

Figure 2c. Multiple Births of Twins With Differing Dates of Birth. NICU-Admitted Twin's Claim. DRG-Reimbursed Hospital.

**Vaginal Delivery Prior to Hospital Admission: DRG-Reimbursed Hospital**

*Figures 3a and 3b. Vaginal delivery prior to hospital admission. Diagnosis-related groups (DRG)-reimbursed hospital.*

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

Case Description

A mother vaginally delivers a healthy newborn at home on August 10. The mother and her healthy newborn are admitted to the hospital on August 11.

Overview of Policy

No TAR is required for admission of the mother or the baby. TARs are not required for delivery or well-baby services associated with a delivery.

Mother's Claim

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

Enter the date of the mother's admission, August 11, 2013, in six-digit format (081113) in the *Admission Date* field (Box 12). Enter the 5 a.m. hour of admission in military terms (5) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "4" indicates a newborn. In the *Source of Admission* field (Box 15) enter a "4," which is required for extramural births.

The total length of the mother's stay is entered in the *Statement Covers Period* field (Box 6). Enter the day of admission (081113) as the "From" date and the day of discharge as the "Through" date. In this case, the discharge date is August 13 (081313). Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 11 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the mother was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 – 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 159 is entered in the *Revenue Code* field (Box 42) to bill services for the mother. Enter the description of code 159 (room and board, ward) in the *Description* field (Box 43). Enter a “2” in the *Service Units* field (Box 46) to indicate the number of days the mother stayed in the hospital. Do not count the day of discharge.

All ancillary services are listed. 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, line 23) to designate that this is the total charge line and enter the totals of all charges in “TOTALS” (Box 47, line 23).

Enter an appropriate primary ICD-9-CM diagnosis code in Box 67. In this case, ICD-9-CM diagnosis code 664.11 indicates second degree perineal laceration. Code V27.0 is entered as the secondary diagnosis code and indicates birth of a single live newborn. These codes are entered on the claim as 66411 and V270, respectively.

**Note:** Hospitals reimbursed under 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.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, the perineal laceration (code 664.11) was present on admission and requires a “Y” (yes) POA. Diagnosis code V27.0 is exempt from POA reporting requirements.

ICD-9-CM Volume 3 procedure code 73.99 (other operations assisting delivery, other) is an acceptable code to be entered in the *Principal Procedure* field (Box 74) as 7399. Additionally ICD-9-CM Volume 3 procedure code 75.69 (repair of obstetric laceration) is entered. The dates of the procedures, August 11, 2013, are entered as 081113.

**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.

The date of birth is included in the *Remarks* field (Box 80).

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 first *Other* field (Box 78).

Newborn's Claim

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

Enter the date of the baby's admission, August 11, 2013, in six-digit format (081113) in the *Admission Date* field (Box 12). Enter the 5 a.m. hour of admission in military terms (5) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "4" indicates a newborn. In the *Source of Admission* field (Box 15) enter a "4" to indicate an extramural birth.

The total length of the baby's stay is entered in the *Statement Covers Period* field (Box 6). Enter the day of admission (081113) as the "From" date and the day of discharge as the "Through" date. In this case, the discharge date is August 13 (081313). Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 11 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the baby was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 – 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 171 is entered in the *Revenue Code* field (Box 42) to bill services for the well baby. Enter the description of code 171 (nursery newborn, Level I) in the *Description* field (Box 43). Enter a "2" in the *Service Units* field (Box 46) to indicate the number of days the baby stayed in the hospital. Do not count the day of discharge.

All ancillary services are listed. 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, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Enter an appropriate primary ICD-9-CM diagnosis code in Box 67. In this case, ICD-9-CM diagnosis code V30.1 represents a single liveborn baby born before admission to the hospital. 765.29 indicates gestation age of a single live newborn at more than 37 weeks. The codes are entered on the claim as V301 and 76529, respectively.

**Note:** Hospitals reimbursed under 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. The primary diagnosis should be the appropriate V30.00 – V39.21 code for the birth episode.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, diagnosis code V30.1 is exempt from POA reporting requirements. Code 765.29 requires a “Y” (yes) POA.

No procedures were performed on the baby so the *Principal Procedure* field (Box 74) is left blank.

**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.

The date of birth is included in the *Remarks* field (Box 80).

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 first *Other* field (Box 78).

ob ub ex drg  
22

1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555										2	3a PAT CNTL #	3b MED REC #	4 TYPE OF BILL	111					
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH	081113	081313	8 PATIENT NAME	a	9 PATIENT ADDRESS	a	b	c	d	e								
10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37 OCCURRENCE CODE	38 OCCURRENCE DATE	39 OCCURRENCE CODE	40 OCCURRENCE DATE	41 OCCURRENCE CODE	42 OCCURRENCE DATE	43 OCCURRENCE CODE	44 OCCURRENCE DATE	45 OCCURRENCE CODE	46 OCCURRENCE DATE	47 OCCURRENCE CODE	48 OCCURRENCE DATE	49 OCCURRENCE CODE	50 OCCURRENCE DATE	51 OCCURRENCE CODE
38	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	50	51	52	53	54	55	56	57	58	59	60	61	62
1	159	ROOM & BOARD, WARD		2	400000															
2	250	GENERAL PHARMACY			11025															
3	300	GENERAL LABORATORY			43900															
4	720	LABOR ROOM/DELIVERY GEN.			64000															
5	710	RECOVERY ROOM GENERAL			43500															
6																				
7																				
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22																				
23	001	PAGE	OF	CREATION DATE	TOTALS	562425														
A	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID	58 INSURED'S NAME	59 PREL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.							
B	I/P MEDI-CAL					562425	0123456789				90000000A95001									
C	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	66	67	68	69	70	71	72	73	74	75							
A	68 DX	69 ADMIT DX	70 PATIENT REASON DX	71 FFS CODE	72 ECI	73	74	75	76	77	78	79	80							
B	66411	Y	V270																	
C	74	75	76	77	78	79	80	81	82	83	84	85	86							
A	7399	081113	7569	081113																
B	76	77	78	79	80	81	82	83	84	85	86	87	88							
C	76	77	78	79	80	81	82	83	84	85	86	87	88							
A	80 REMARKS	81 CC	82	83	84	85	86	87	88	89	90	91	92							
B	DELIVERY DATE 081013	a	b	c	d	e	f	g	h	i	j	k	l							
C																				

Figure 3a. Vaginal Delivery Prior to Hospital Admission. Mother's Claim. DRG-Reimbursed Hospital.

1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555													3a PAT CNTL # b. MED REC. #		4 TYPE OF BILL 111																				
8 PATIENT NAME a													9 PATIENT ADDRESS a													5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 081113		7 THROUGH 081313						
b	DOE BABY													c		d		e																		
10	BIRTHDATE	11	SEX	12	DATE	13	ADMISSION	14	TYPE	15	SRC	16	DHR	17	STAT	18	19	20	21	22	23	24	25	26	27	28	29	ACDT	30	STATE						
31	OCCURRENCE	32	OCCURRENCE	33	OCCURRENCE	34	OCCURRENCE	35	OCCURRENCE	36	OCCURRENCE	37	OCCURRENCE	38	OCCURRENCE	39	OCCURRENCE	40	OCCURRENCE	41	OCCURRENCE	42	OCCURRENCE	43	OCCURRENCE	44	OCCURRENCE	45	OCCURRENCE	46	OCCURRENCE	47	OCCURRENCE	48	OCCURRENCE	49
31	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
38	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
39	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
42	REV. CD.	43	DESCRIPTION	44	HCPCS / RATE / HIPPS CODE	45	SERV. DATE	46	SERV. UNITS	47	TOTAL CHARGES	48	NON-COVERED CHARGES	49																						
1	171	NURSERY NEWBORN, LEVEL I	2	300	GENERAL LABORATORY	2	60000	20300																												
23	001	PAGE	OF	CREATION DATE	TOTALS	80300																														
50	PAYER NAME	51	HEALTH PLAN ID	52	REL INFO	53	ASG BEN	54	PRIOR PAYMENTS	55	EST. AMOUNT DUE	56	NPI	57	OTHER	58	PRV ID																			
A	I/P MEDI-CAL									80300		0123456789																								
58	INSURED'S NAME	59	P. REL	60	INSURED'S UNIQUE ID	61	GROUP NAME	62	INSURANCE GROUP NO.																											
A	JANE DOE	03	90000000A95001																																	
83	TREATMENT AUTHORIZATION CODES	84	DOCUMENT CONTROL NUMBER	85	EMPLOYER NAME																															
A																																				
66	DX	67	76529	68	Y	69	ADMIT	70	PATIENT	71	PPS	72	ECL	73																						
74	PRINCIPAL	75	OTHER	76	OTHER	77	ATTENDING	78	OPERATING	79	OTHER	80	OTHER	81																						
a	DATE	b	DATE	c	DATE	NPI	1234567890	NPI	2345678901	NPI	3456789012	QUAL	QUAL	QUAL																						
80	REMARKS	81	CC	82	CC	83	CC	84	CC	85	CC	86	CC	87																						
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80	REMARKS	81	CC	82	CC	83	CC	84	CC	85	CC	86	CC	87																						
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80	REMARKS	81	CC	82	CC	83	CC	84	CC	85	CC	86	CC	87																						
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80	REMARKS	81	CC	82	CC	83	CC	84	CC	85	CC	86	CC	87																						
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80	REMARKS	81	CC	82	CC	83	CC	84	CC	85	CC	86	CC	87																						
a	DATE	b	DATE																																	