

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

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UB-04 Completion: Inpatient Services

The *UB-04* claim form is used to submit claims for inpatient hospital accommodations (for example, medical/surgical intensive care, burn care and coronary care) and ancillary charges (for example, labor and delivery, anesthesiology and central services and supplies).

Most claims for inpatient services can also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the *CMC* section in the Part 1 manual.

Important additional billing information is included in the following sections of this manual:

- *Diagnosis-Related Groups (DRG): Inpatient Services*
- *UB-04 Special Billing Instructions for Inpatient Services*
- *UB-04 Submission and Timeliness Instructions*
- *UB-04 Tips for Billing: Inpatient Services*

For crossover billing information, refer to the *Medicare/Medi-Cal Crossover Claims: Inpatient Services* and *Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples* sections.

Medi-Cal does not process credits or adjustments on the *UB-04* claim form. Refer to the *CIF Completion* and *CIF Special Billing Instructions for Inpatient Services* sections in this manual for information about claim adjustments.

1 HOSPITAL NAME	2	3a PAT. CNTL. #	4 TYPE OF BILL
ADDRESS		b MED. REC. #	TYPE OF BILL
CITY STATE ZIP CODE		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b PATIENT NAME			
10 BIRTHDATE	11 SEX	12 DATE	13 ADMISSION HR
14 TYPE	15 SRC	16 DHR	17 STAT
18	19	20	21
22	23	24	25
26	27	28	29 ACOT STATE
30			
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE
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839	840	841	842
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859	860	861	862
863	864	865	866
867	868	869	870
871	872	873	874
875	876	877	878
879	880	881	882
883	884	885	886

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *UB-04* on the previous page. All items must be completed unless otherwise noted.

Note: Items described as “Not required by Medi-Cal” may be completed for other payers, but are not recognized by the Medi-Cal claims processing system.

Item Description

1. **UNLABELED (Use for hospital information).** Enter the hospital name. Enter the address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. A telephone number is optional in this field.

Note: The nine-digit zip code entered in this box must match the biller’s zip code on file for claims to be reimbursed correctly.

2. **UNLABELED.** For FI use only. This field must be left blank on all claims submitted to Medi-Cal.

3A. **PATIENT CONTROL NUMBER.** This is an optional field that will help you to easily identify a recipient on *Resubmission Turnaround Documents (RTDs)* and *Remittance Advices (RAs)*. Enter the patient’s financial record number or account number in this field. A maximum of 20 numbers and/or letters may be used, but only 10 characters will appear on the RTD and RA. Refer to the *Remittance Advice Details (RAD) Examples: Inpatient Services* section in this manual for patient control number information.

3B. **MEDICAL RECORD NUMBER.** Not required by Medi-Cal. Use Box 3A to enter a patient control number. This number will not appear on the RTD or RAD for recipient clarification. The patient control number (Item 3) will appear on the RTD and RAD.

4. **TYPE OF BILL.** Enter the appropriate three-character type of bill code as specified in the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual*. This is a required field when billing Medi-Cal.

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 5. | FEDERAL TAX NUMBER. Not required by Medi-Cal. |
| 6. | STATEMENT COVERS PERIOD (FROM – THROUGH). In six-digit MMDDYY (Month, Day, Year) format, enter the dates of service included in this billing. The date of discharge should be entered in the <i>THROUGH</i> Box, even though this date is not reimbursable (unless the day of discharge is the date of admission).

For “From-Through” billing instructions, refer to the <i>UB-04 Special Billing Instructions for Inpatient Services</i> section in this manual. |
| 7. | UNLABELED. Not required by Medi-Cal. |
| 8A. | PATIENT NAME – ID. Not required by Medi-Cal. |
| 8B. | PATIENT NAME. Enter the patient’s last name, first name and middle initial (if known). Avoid nicknames or aliases. |

Newborn Infant

When submitting a claim for a newborn infant using the mother’s ID number, enter the infant’s name in Box 8B. If the infant has not yet been named, write the mother’s last name followed by “Baby Boy” or “Baby Girl” (example: Jones Baby Girl). If billing for newborn infants from a multiple birth, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A) on separate claims.

Refer to the *Obstetrics: UB-04 Billing Examples for Inpatient Services – DRG Payment Method* section in this manual for various billing examples relating to birth.

Enter the infant’s date of birth and sex in Boxes 10 and 11. Enter the mother’s name in Box 58 (*Insured’s Name*), and enter “03” (CHILD) in Box 59 (*Patient’s Relationship to Insured*).

Organ Donors

Item Description

When submitting a claim for a patient donating an organ to a Medi-Cal recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Medi-Cal recipient's name in Box 58 (*Insured's Name*) and enter "11" (DONOR) in Box 59 (*Patient's Relationship to Insured*).

9A – E. **PATIENT ADDRESS.** Not required by Medi-Cal.

10. **BIRTHDATE.** Enter the patient's date of birth in an eight-digit MMDDYYYY (Month, Day, Year) format (for example, September 16, 1967 = 09161967). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns and organ donors, see Item 8B on a previous page.)

11. **SEX.** Use the capital letter "M" for male, or "F" for female. Obtain the sex indicator from the Benefits Identification Card. (For newborns and organ donors, see Item 8B on a previous page.)

12 – 13. **ADMISSION DATE AND HOUR.** In a six-digit format, enter the date of hospital admission. Enter the admit hour as follows:

- Eliminate the minutes
- Convert the hour of admission/discharge to 24-hour (00 – 23) format (for example, 3 p.m. = 15)

14. **ADMISSION TYPE.** Enter the numeric code indicating the necessity for admission to the hospital:

- Emergency – 1
- Elective – 3
- Newborn – 4

If the delivery was outside the hospital, use admit type code "1" (emergency) in the Type of Admission, and admission source code "4" (extramural birth) in the Source of Admission field (Box 15)

Item Description

15. **ADMISSION SOURCE.** If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. When completing this field, code “1” or “3” must be entered in Box 14 to indicate whether the transfer was an emergency or elective.

Source of Admission

<u>Code</u>	<u>Description</u>
4	Transfer from a hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from another health care facility

Baby born outside the hospital: In cases where the type of admission code in Box 14 is “4” (newborn [used by Medi-Cal only when baby is born outside the hospital]), submit the claim with source of admission code “4” (extramural birth) in Box 15 and the appropriate revenue code in Box 42.

16. **DISCHARGE HOUR.** Enter the discharge hour as follows:
- Eliminate the minutes
 - Convert the hour of discharge to 24-hour (00 – 23) format (for example, 3 p.m. = 15)

If the patient has not been discharged, leave this box blank.

<u>Item</u>	<u>Description</u>																																								
17.	STATUS. Enter one of the following numeric codes to explain patient status as of the "Through" date indicated in (Box 6) under "Statement Covers Period."																																								
	<table border="0" style="margin-left: 40px;"> <thead> <tr> <th style="text-align: left;"><u>Code</u></th> <th style="text-align: left;"><u>Explanation</u></th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Discharged to home or self care (routine discharge)</td> </tr> <tr> <td>02</td> <td>Discharged/transferred to a short-term general hospital for inpatient care</td> </tr> <tr> <td>03</td> <td>Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care</td> </tr> <tr> <td>04</td> <td>Discharged/transferred to an Intermediate Care Facility</td> </tr> <tr> <td>05</td> <td>Discharged/transferred to another type of health care institution not defined elsewhere in this code list</td> </tr> <tr> <td>06</td> <td>Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care</td> </tr> <tr> <td>07</td> <td>Left against medical advice or discontinued care</td> </tr> <tr> <td>09</td> <td>Admitted as inpatient to this hospital</td> </tr> <tr> <td>20</td> <td>Expired</td> </tr> <tr> <td>30</td> <td>Still a patient</td> </tr> <tr> <td>40</td> <td>Expired at home</td> </tr> <tr> <td>41</td> <td>Expired in a medical facility</td> </tr> <tr> <td>42</td> <td>Expired – place unknown</td> </tr> <tr> <td>43</td> <td>Discharged/transferred to a federal health care facility</td> </tr> <tr> <td>50</td> <td>Hospice – home</td> </tr> <tr> <td>51</td> <td>Hospice – medical facility</td> </tr> <tr> <td>61</td> <td>Discharged/transferred within this institution to hospital-based Medicare-approved swing bed</td> </tr> <tr> <td>62</td> <td>Discharged/transferred to an inpatient rehabilitation facility, including rehabilitation distinct part units of a hospital</td> </tr> <tr> <td>63</td> <td>Discharged/transferred to a Medicare certified Long Term Care hospital</td> </tr> </tbody> </table>	<u>Code</u>	<u>Explanation</u>	01	Discharged to home or self care (routine discharge)	02	Discharged/transferred to a short-term general hospital for inpatient care	03	Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care	04	Discharged/transferred to an Intermediate Care Facility	05	Discharged/transferred to another type of health care institution not defined elsewhere in this code list	06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care	07	Left against medical advice or discontinued care	09	Admitted as inpatient to this hospital	20	Expired	30	Still a patient	40	Expired at home	41	Expired in a medical facility	42	Expired – place unknown	43	Discharged/transferred to a federal health care facility	50	Hospice – home	51	Hospice – medical facility	61	Discharged/transferred within this institution to hospital-based Medicare-approved swing bed	62	Discharged/transferred to an inpatient rehabilitation facility, including rehabilitation distinct part units of a hospital	63	Discharged/transferred to a Medicare certified Long Term Care hospital
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Item Description

17. **STATUS (continued).**

Code Explanation

- | | |
|----|--|
| 64 | Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare |
| 65 | Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital |
| 66 | Discharged/transferred to a Critical Access Hospital (CAH) |

18 – 24. **CONDITION CODES.** Condition codes are used to identify conditions relating to this claim that may affect payer processing.

Although the Medi-Cal claims processing system only recognizes the condition codes on the following pages, providers may include codes accepted by other payers. The claims processing system ignores all codes not applicable to Medi-Cal.

Condition codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing for three condition codes, “A1”, “80” and “82”, enter “80” in Box 18, “82” in Box 19 and “A1” in Box 20.

Applicable Medi-Cal codes are:

Other Coverage: Enter code “80” if recipient has Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient’s health care needs. Eligibility under Medicare or a Medi-Cal managed care plan is not considered OHC and is identified separately.

Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient’s other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in the Part 1 manual.

<u>Item</u>	<u>Description</u>
18 – 24.	<p>CONDITION CODES (continued).</p> <p><u>Emergency Certification:</u> Enter code “81” when billing for emergency services, or the claim may be reduced or denied. An Emergency Certification Statement must be attached to the claim or entered in the <i>Remarks</i> field (Box 80). The statement must be signed by the attending provider. It is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required authorization, such as emergency services by allergists, podiatrists, medical transportation providers, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist’s statement describing the nature of the emergency, including relevant clinical information about the patient’s condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the <i>Remarks</i> field (Box 80), attach the statement to the claim.</p>

<u>Item</u>	<u>Description</u>
18 – 24.	CONDITION CODES (continued).

Family Planning/CHDP: Enter code "AI" or "A4" if the services rendered are related to Family Planning (FP). Enter code "A1" if the services rendered are Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.

Submit a separate claim form for bills that contain more than one FP/CHDP code.

<u>Code</u>	<u>Description</u>
A1	EPSDT/CHDP
A4	Family Planning
AI	Sterilization/Sterilization <i>Consent Form</i> (PM 330) must be attached if code "AI" is entered

<u>Item</u>	<u>Description</u>																												
18 – 24.	<p>CONDITION CODES (continued).</p> <p><u>Medicare Status:</u> Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional; therefore, providers may leave this area of the <i>Condition Codes</i> fields (Boxes 18 – 24) blank on the <i>UB-04</i> claim. The Medicare status codes are:</p> <table border="0" style="margin-left: 40px;"> <thead> <tr> <th style="text-align: center;"><u>Code</u></th> <th style="text-align: center;"><u>Description</u></th> </tr> </thead> <tbody> <tr> <td>Y0</td> <td>Under 65, does not have Medicare coverage</td> </tr> <tr> <td>Y1 *</td> <td>Benefits exhausted</td> </tr> <tr> <td>Y2 *</td> <td>Utilization committee denial or physician non-certification</td> </tr> <tr> <td>Y3 *</td> <td>No prior hospital stay</td> </tr> <tr> <td>Y4 *</td> <td>Facility denial</td> </tr> <tr> <td>Y5 *</td> <td>Non-eligible provider</td> </tr> <tr> <td>Y6 *</td> <td>Non-eligible recipient</td> </tr> <tr> <td>Y7 *</td> <td>Medicare benefits denied or cut short by Medicare intermediary</td> </tr> <tr> <td>Y8</td> <td>Non-covered services</td> </tr> <tr> <td>Y9 *</td> <td>PSRO denial</td> </tr> <tr> <td>Z1 *</td> <td>Medi/Medi Charpentier: Benefit Limitations</td> </tr> <tr> <td>Z2 *</td> <td>Medi/Medi Charpentier: Rates Limitations</td> </tr> <tr> <td>Z3 *</td> <td>Medi/Medi Charpentier: Both Rates and Benefit Limitations</td> </tr> </tbody> </table> <p>* Documentation required. Refer to the <i>Medicare/Medi-Cal Crossover Claims: Inpatient Services</i> section in this manual for more information.</p>	<u>Code</u>	<u>Description</u>	Y0	Under 65, does not have Medicare coverage	Y1 *	Benefits exhausted	Y2 *	Utilization committee denial or physician non-certification	Y3 *	No prior hospital stay	Y4 *	Facility denial	Y5 *	Non-eligible provider	Y6 *	Non-eligible recipient	Y7 *	Medicare benefits denied or cut short by Medicare intermediary	Y8	Non-covered services	Y9 *	PSRO denial	Z1 *	Medi/Medi Charpentier: Benefit Limitations	Z2 *	Medi/Medi Charpentier: Rates Limitations	Z3 *	Medi/Medi Charpentier: Both Rates and Benefit Limitations
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Z3 *	Medi/Medi Charpentier: Both Rates and Benefit Limitations																												
25 – 28.	<p>CONDITION CODES. The Medi-Cal claims processing system only recognizes condition codes entered in Boxes 18 – 24.</p>																												
29.	<p>ACDT STATE. Not required by Medi-Cal.</p>																												
30.	<p>UNLABELED. Not required by Medi-Cal.</p>																												

Item Description

31 – 34 A – B. **OCCURRENCE CODES AND DATES.** Occurrence codes and dates are used to identify significant events relating to a claim that may affect payer processing.

Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. For example, if billing for two occurrence codes "24" (accepted by another payer) and "05" (accident/no medical or liability coverage), enter "05" in Box 31A and "24" in Box 32A. Refer to *Figure 2* below.

	31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE DATE
a	05 060907	24 060907			
b					
38					

Figure 2. Occurrence Codes Example.

Although the Medi-Cal claims processing system will only recognize applicable Medi-Cal codes, providers may include codes and dates billed to other payers in Boxes 31 – 34. The claims processing system will ignore all codes not applicable to Medi-Cal.

Applicable Medi-Cal codes are:

Enter code "04" (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter one of the following codes if the accident or injury was non-employment related:

<u>Code</u>	<u>Description</u>
01	Accident/medical coverage
02	No fault insurance involved – including auto accident/other
03	Accident/tort liability
05	Accident/no medical or liability coverage
06	Crime victim

In six-digit MMDDYY (Month, Day, Year) format, enter the date of accident/injury in the corresponding box.

- | <u>Item</u> | <u>Description</u> |
|----------------|--|
| 31 – 34 A – B. | OCCURRENCE CODES AND DATES (continued).

DISCHARGE DATE. In six-digit MMDDYY (Month, Day, Year) format, enter code “42” and the date of hospital discharge when the date of discharge is different than the “Through” date in Box 6. |
| 35 – 36 A – B. | OCCURRENCE SPAN CODES AND DATES. Not required by Medi-Cal. |
| 37A. | UNLABELED (Use for delay reason codes). Enter one of the following delay reason codes, and include the required documentation, if there is an exception to the six-month from the month of service billing limit. |

<u>Code</u>	<u>Description</u>	<u>Documentation</u>
1	Proof of Eligibility unknown or unavailable	Remarks/ Attachment
3	Authorization delays	Remarks
4	Delay in certifying provider	Remarks
5	Delay in supplying billing forms	Remarks
6	Delay in delivery of custom-made appliances	Remarks
7	Third party processing delay	Attachment
10	Administrative delay in prior approval process (decision appeals)	Attachment
11	Other (no reason)	None *
11	Other (theft, sabotage)	Attachment *
15	Natural disaster	Attachment

* Documentation justifying the delay reason must be attached to the claim to receive full payment. Providers billing with delay reason “11” without an attachment will either receive reimbursement at a reduced rate or a claim denial. Refer to “Reimbursement Reduced for Late Claims” in the *UB-04 Submission and Timeliness Instructions* section of this manual.

For hospitals that are not reimbursed according to the diagnosis-related group (DRG) model: Providers must use claim frequency code “5” in the *Type of Bill* field (Box 4) of the claim when adding a new ancillary code to a previous stay and the original stay was already billed.

Refer to the *UB-04 Submission and Timeliness Instructions* section in this manual for detailed information about codes and documentation requirements.

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 37B. | UNLABELED. Not required by Medi-Cal. |
| 38. | UNLABELED. Not required by Medi-Cal. |

39 – 41 A – D. **VALUE CODES AND AMOUNT. Patient’s Share of Cost.**
Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence, starting with the lowest value. For example, if billing for two value codes “30” (accepted by another payer) and “23” (accepted by Medi-Cal), enter “23” in Box 39A and “30” in Box 40A. (See *Figure 3* below.)

Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the Medi-Cal claims processing system only recognizes code “23,” providers may include codes and dates billed to other payers in Boxes 39 – 41. The claims processing system will ignore all codes not applicable to Medi-Cal.

Enter code “23” and the amount of the patient’s Share of Cost for the procedure or service, if applicable. Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even (for example, if billing for \$100, enter 10000 not 100). For more information about Share of Cost, see the *Share of Cost: UB-04 for Inpatient Services* section in this manual.

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VAL
a	23	5000	30	10000		
b						
c						
d						

Figure 3. Value Codes Example.

Item	Description
42.	<p>REVENUE CODE. Enter the appropriate revenue or ancillary code. Refer to the <i>Revenue Codes for Inpatient Services</i> section in this manual. Ancillary codes are listed in the <i>Ancillary Codes</i> section in this manual.</p> <p>Total Charges: Enter “001” on line 23, and enter the total amount on line 23, field 47.</p>
43.	<p>DESCRIPTION. Enter the description of the revenue or ancillary code used in Box 42. Refer to the <i>Revenue Codes for Inpatient Services</i> and <i>Ancillary Codes</i> sections in this manual for the appropriate description.</p> <p>Note: If there are multiple pages of the claim, enter the page numbers on line 23 in this field.</p>
44.	<p>HCPCS/RATE/HIPPS CODE. Not required by Medi-Cal.</p>
45.	<p>SERVICE DATE. Not required by Medi-Cal.</p>
46.	<p>SERVICE UNITS (Accommodation Days). Enter the number of days of care by revenue code. Units of service are not required for ancillary services.</p> <p>Note: Although this is a seven-digit field, Medi-Cal only allows two digits in this field. If billing for more than 99, divide the units on two or more lines.</p>

<u>Item</u>	<u>Description</u>
47.	<p>TOTAL CHARGES. In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100).</p> <p>Note: Medi-Cal cannot process credits or adjustments on the <i>UB-04</i> claim form. Refer to the <i>CIF Completion</i> and <i>CIF Special Billing Instructions for Inpatient Services</i> sections in this manual for information regarding claim adjustments.</p> <p>Enter the "Total Charge" for all services on Line 23. Enter code 001 in <i>Revenue Code</i> field (Box 42) to indicate that this is the total charge line (refer to Item 42 on a preceding page).</p>

- Item Description
48. **NON-COVERED CHARGES.** Not required by Medi-Cal.
49. **UNLABELED.** Not required by Medi-Cal.

Note: Providers may enter up to 22 lines of detail data (Items 42 – 49). It is also acceptable to skip lines.

To delete a line, mark through the boxes as shown in *Figure 4*. Be sure to draw a thin line through the entire detail line using a blue or black ballpoint pen.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1 205	INTENS CARE PEDIATRIC			12	1800000
2 203	INTENS CARE PEDIATRIC			15	2300000
3 272	MEDICAL/SURGICAL SUPPLY			1	80000
4					

Figure 4. UB-04 Claim: Line Deletion Example.

- 50A – C. **PAYER NAME.** Enter “I/P MEDI-CAL” to indicate type of claim and payer. Use capital letters only. Refer to *Figure 5* below.

When completing Boxes 50 – 65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: Medi-Cal). Do not enter information on Lines A and B for other insurance or Medicare if payment was denied by these carriers.

If Medi-Cal is the only payer billed, all information in Boxes 50 – 65 (excluding Box 56) should be entered on Line A.

Reminder: If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Medi-Cal.

22		
23	001	PAGE C
	50 PAYER NAME	
A	I/P MEDI-CAL	
B		
C		
	58 INSURED'S NAME	

Figure 5. UB-04: Payer Name Example.

<u>Item</u>	<u>Description</u>
51A – C.	HEALTH PLAN ID. Not required by Medi-Cal.
52A – C.	RELEASE OF INFORMATION CERTIFICATION INDICATOR. Not required by Medi-Cal.
53A – C.	ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR. Not required by Medi-Cal.
54A – B.	PRIOR PAYMENT (Other Coverage). Enter the full dollar amount of payment received from Other Health Coverage on the same line as the Other Health Coverage “payer” (Box 50). Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Leave blank if not applicable. Note: For instructions about completing this field for Medicare/Medi-Cal recipients, refer to the <i>Medicare/Medi-Cal Crossover Claims: Inpatient Services</i> section in this manual.

<u>Item</u>	<u>Description</u>								
55A – C.	<p>ESTIMATED AMOUNT DUE (Net amount billed). In full dollar amount, enter the difference between “Total Charges” and any deductions (for example, patient’s Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign (\$).</p> <table border="0" style="margin-left: 40px;"> <tr> <td style="width: 150px;">Total Charges</td> <td>(Box 47) Revenue code 001</td> </tr> <tr> <td>(Minus) – Deductions</td> <td>Share of Cost (Box 39, 40 or 41A – D/ Value code 23) and Other Coverage (Box 54A or B)</td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black; padding-top: 5px;">(Equals) = Net Billed</td> </tr> <tr> <td></td> <td>(Boxes 55A – C)</td> </tr> </table>	Total Charges	(Box 47) Revenue code 001	(Minus) – Deductions	Share of Cost (Box 39, 40 or 41A – D/ Value code 23) and Other Coverage (Box 54A or B)	(Equals) = Net Billed			(Boxes 55A – C)
Total Charges	(Box 47) Revenue code 001								
(Minus) – Deductions	Share of Cost (Box 39, 40 or 41A – D/ Value code 23) and Other Coverage (Box 54A or B)								
(Equals) = Net Billed									
	(Boxes 55A – C)								
56.	<p>NPI. Enter the National Provider Identifier (NPI).</p>								
57A – C.	<p>OTHER (BILLING) PROVIDER ID (Used by atypical providers only). Not required by Medi-Cal for inpatient providers.</p> <p>Note: Required prior to the mandated NPI implementation date when an additional identification number is necessary to identify the provider, or if on and after the mandated NPI implementation, the NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.</p>								
58A – C.	<p>INSURED’S NAME. If billing for an infant using the mother’s ID or for an organ donor, enter the Medi-Cal recipient’s name here and the patient’s relationship to the Medi-Cal recipient in Box 59 (<i>Patient’s Relationship to Insured</i>). See Item 8B on a previous page in this section. This box is not required by Medi-Cal except under the two circumstances listed here.</p>								
59A – C.	<p>PATIENT’S RELATIONSHIP TO INSURED. If billing for an infant using the mother’s ID or for an organ donor, enter the code indicating the patient’s relationship to the Medi-Cal recipient (for example, “03” [CHILD] or “11” [DONOR]). See Item 8B on a previous page in this section. This box is not required by Medi-Cal except under the two circumstances listed here.</p>								

	<u>Item</u>	<u>Description</u>
	60A – C.	INSURED’S UNIQUE ID. Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal ID card. Note: Medi-Cal does not accept Medicare Health Insurance Claim (HIC) numbers.
Newborn Infant		When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother’s ID number in this field. (For more information, see Item 8B on a previous page.)
	61A – C.	GROUP NAME. Not required by Medi-Cal.
	62A – C.	INSURANCE GROUP NUMBER. Not required by Medi-Cal.
	63A – C.	TREATMENT AUTHORIZATION CODES. For services requiring a <i>Treatment Authorization Request (TAR)</i> , enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim.
Extension TAR Control Numbers		Inpatient claims must be submitted with a TAR Control Number, even if an extension TAR was issued for the same stay. (Enter the extension TAR Control Number in the <i>Remarks</i> field [Box 80].) Note: TAR-approved inpatient stays should not be billed on the same claim with inpatient stays that do not require a TAR.

<u>Item</u>	<u>Description</u>
64A – C.	DOCUMENT CONTROL NUMBER. Not required by Medi-Cal.
65A – C.	EMPLOYER NAME. Not required by Medi-Cal.
66.	DIAGNOSIS CODE HEADER. For claims with a diagnosis code that will be received by the Fiscal Intermediary (FI) on or after September 22, 2014, enter the appropriate ICD indicator “9” in the white space below the <i>Diagnosis Code</i> field (Box 66). No ICD indicator is required if the claim is submitted without a diagnosis code.

67. **UNLABELED (Use for primary diagnosis code).** Enter all letters and/or numbers of the ICD-9-CM code for the primary diagnosis, including fourth and fifth digits if present. Do not enter a decimal point when entering the code.

Present on admission (POA) indicator: Each diagnosis code may require a POA indicator that meets Centers for Medicare & Medicaid Services (CMS) standards. Enter POA indicators in the shaded area on the right side of Boxes 67 – 67Q. See *Figure 6* in Item 67A.

Note: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A.

However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all diagnosis code fields (Boxes 67 – 67Q) so the claim is reimbursed at the appropriate level.

Paper claims accommodate up to 18 diagnosis codes.

- | Item | Description |
|------|--|
| 67A. | <p>UNLABELED (Use for secondary diagnosis code). If applicable, enter all letters and/or numbers of the ICD-9-CM code for the secondary diagnosis, including fourth and fifth digits if present. Do not enter a decimal point when entering the code.</p> |

Present on admission (POA) indicator: Each diagnosis code may require a POA indicator that meets CMS standards. Enter POA indicators in the shaded area on the right side of Boxes 67 – 67Q.

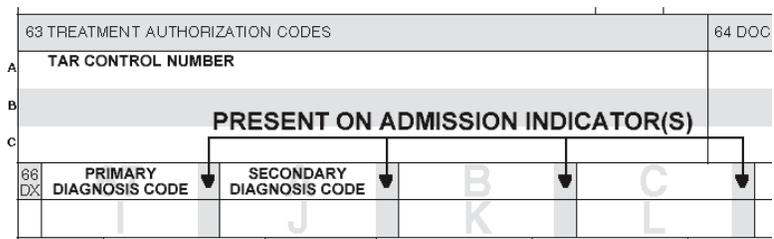


Figure 6. Arrows show shaded areas where present on admission (POA) indicators are placed; next to their associated diagnosis codes.

Note: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A.

However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all diagnosis code fields (Boxes 67 – 67Q) so the claim is reimbursed at the appropriate level.

Paper claims accommodate up to 18 diagnosis codes.

<u>Item</u>	<u>Description</u>
67B – Q.	UNLABELED. Not required by Medi-Cal. See “Note” in Item 67A.
68.	UNLABELED. Not required by Medi-Cal.
69.	ADMITTING DIAGNOSIS. Not required by Medi-Cal.
70.	PATIENT REASON DIAGNOSIS. Not required by Medi-Cal.
71.	PPS CODE. Not required by Medi-Cal.
72.	EXTERNAL CAUSE OF INJURY CODE. Not required by Medi-Cal.
73.	UNLABELED. Not required by Medi-Cal.

<u>Item</u>	<u>Description</u>
74.	<p>PRINCIPAL PROCEDURE CODE AND DATE. Enter the appropriate ICD-9-CM Volume 3 procedure code identifying the primary medical or surgical procedure. In six-digit MMDDYY (Month, Day, Year) format, enter the date the surgery or delivery was performed. Enter the ICD-9-CM Volume 3 procedure code, without periods or spaces between the numbers.</p> <p>Note: The Medi-Cal claims processing system only scans the primary and secondary procedure codes entered in Boxes 74 and 74A.</p> <p>However, for claims reimbursed according to the diagnosis-related groups (DRG) method, separate DRG-grouper software views and assesses codes entered in all procedure code fields (Boxes 74 – 74E) so the claim is reimbursed at the appropriate level.</p> <p>Paper claims accommodate up to six procedure codes.</p>
74A – E.	<p>OTHER PROCEDURE CODES AND DATES. Enter the appropriate ICD-9-CM Volume 3 procedure code identifying the secondary medical or surgical procedure. Enter the ICD-9-CM Volume 3 procedure code, without periods or spaces between the numbers.</p> <p>Note: For OB vaginal or cesarean delivery and transplants, enter the appropriate ICD-9-CM Volume 3 procedure code in either Box 74 or 74A – E.</p> <p>Also see the “Note” in Item 74.</p>
75.	<p>UNLABELED. Not required by Medi-Cal.</p>

<u>Item</u>	<u>Description</u>
76.	ATTENDING. In the first box, enter the attending physician's NPI. Do not use a group provider number. The attending physician's first and last name are not required by Medi-Cal.
77.	OPERATING. In the first box, enter the operating physician's NPI. Do not use a group provider number. The operating physician's first and last name are not required by Medi-Cal.
78.	OTHER (Use for admitting physician provider number). In the first box, enter the admitting physician's NPI. Do not use a group provider number. The admitting physician's first and last name is not required by Medi-Cal.
79.	OTHER. Not required by Medi-Cal.
80.	REMARKS. Use this area for procedures that require additional information, justification or an Emergency Certification Statement. The Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, medical transportation providers, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the <i>Remarks</i> field (Box 80), attach the statement to the claim.
81A – D.	CODE-CODE. Not required by Medi-Cal.