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CMS-1450 UB-04 coding and billing overview

What story does the claim coding tell?

Presenter:
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Administrative notes for today's training

Audio tips:

- WebEx allows you to join the audio **either** through your phone or computer. Please select one of these options. If you have your computer audio linked **and** your phone, this may cause feedback.
- The host will be muting all phone lines to ensure that everyone is able to hear the presentation.

Questions:

- If you have a question, please feel free to type it into the WebEx chat window. If we need additional clarification, we will unmute your line. If you are using your computer for audio, please ensure your mic is enabled.
- There will also be time at the end of our presentation for everyone to ask questions.
- All questions and answers will be logged, emailed out to attendees and posted on our website for future reference.

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Why a story?

- I would like to introduce the idea that a claim is actually telling a story. A story of a patient's journey through your facility.
- With each code field on the claim form flowing into the next fields, those codes are read and put together like a piece of a puzzle or the clues to a mystery.
- When the claim's coding does not have a consistent story, that is where questions, delays and denials are experienced.
- When telling a story you must always have a beginning, a middle and an end. The flow of the facts assist the claims processing system as well as the claims processors to see the big picture of what is happening and how to make a determination for the proper next steps.
- All claim form coding is required to match the patient's medical records and chart notes.
- Who, what, when, where, how and why did this admission come about?

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UB-04 type of bill first digit — where is the patient?

Type of bill codes (Field 4): This is a three-digit code; each digit is defined

1st Digit – Type of Facility	Code
Hospital	1
Skilled Nursing Facility	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7

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UB-04 type of bill second digit — where is the patient?

2nd Digit – Bill Classifications (Excluding Clinics & Special Facilities)	Code
Inpatient	1
Outpatient	3
Other (For Hospital Referenced Diagnostic Services, or Home Health Not Under a Plan of Treatment)	4
Intermediate Care, Level I	5
Intermediate Care, Level II	6
Intermediate Care, Level III	7
Swing Beds	8
2nd Digit – Bill Classifications (Clinics Only)	**Code**
Rural Health	1
Hospital Based or Independent Renal Dialysis Center	2
Free Standing	3
Other Rehabilitation Facility (ORF)	4
Other	9
2nd Digit – Bill Classifications (Special Facility Only)	**Code**
Hospice (Non-Hospital Based)	1
Hospice (Hospital Based)	2
Ambulatory Surgery Center (ASC)	3
Freestanding Birthing Center	4

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UB-04 type of bill third digit — where is the patient?

3rd Digit – Frequency	Code
Admit through Discharge Claim	1
Interim – First Claim	2
Interim – Continuing Claims	3
Interim – Last Claim	4
Late Charge only	5
Adjustment of Prior Claim	6
Replacement of Prior Claim	7
Void/Cancel of Prior Claim	8

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The admission type and the admission source coding

The admission type and the admission source coding will need to be paired with coding that clearly tells the following:

Why did this patient present to your facility?

- Emergency?
- Elective?

Where was the patient prior to this admission?

- Transfer from a hospital?
- Emergency room?
- Physician's office?
- Unknown?

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Admission type code — why was the patient admitted?

Type of admission codes (Field 19)

Code	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
9	Information Not Available

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Admission source code — where did the patient come from?

Source of admission codes except newborns (Field 20)

Code	Definition
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a Skilled Nursing Facility (SNF)
6	Transfer from Another Health Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
10	Transfer from Psych Substance Abuse or Rehab Hospital
11	Transfer from a Critical Access Hospital

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How the admission type and admission source work together

An admission code type 3 — Elective would not pair with Admission Source Code 8 — Court/Law Enforcement.

- That coding is stating that the admission was Elective, but the Admission Source Code is Court/Law Enforcement, which indicates that the admission was not voluntary or elective. The Elective admission code would not pair with the Admission source coding, which would cause a claim denial.

A common scenario that can occur is that the patient presents on an Elective basis yet the Admission Source is unknown.

- In that scenario an Admission Source code 9 — Information Unavailable is appropriate.
- All claim form coding is required to match the patient's medical records and chart notes.

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Discharge status code — Field 22 — where is the patient now?

Code	Definition
01	Discharged to Home or Self-Care (Routine Discharge)
02	Discharged/Transferred to Another Short-Term General Hospital
03	Discharged/Transferred to an SNF
04	Discharged/Transferred to an Intermediate Care Facility (ICF)
05	Discharged/Transferred to Another Type of Institution (Including Distinct Parts) or Referred for Outpatient Services to Another Institution
06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
07	Left Against Medical Advise or Discontinued Care
08	Discharged/Transferred to Home Under Care of Home IV Therapy Provider
09	Admitted as an Inpatient to this Hospital
20	Expired (or Did Not Recover-Christian Science Patient)
30	Still a Patient or Expected to Return for Outpatient Services
31 – 39	Still Patient to be Defined at State Level, if Necessary
40	Expired at Home (for Hospice Care Only)
41	Expired in a Medical Facility such as a Hospital, SNF, ICF or Freestanding Hospice (for Hospice Care Only)
42	Expired, Place Unknown (for Hospice Care Only)
50	Discharged to Hospice-Home
51	Discharged to Hospice-Medical Facility

Discharge status code — where is the patient now?

Patient status codes (Field 22)

- The Discharge Status code is another necessary identifier that is telling the story of where the patient is currently located and/or the location to which they were discharged.

An example of a billing error:

- Amerigroup Washington, Inc. receives a claim from a residential treatment center with a discharge status of 01 —Discharged to Home or Self-Care and then the next month receives another claim from the center indicating the patient is Discharge Status 30 —Still A Patient. The second will likely deny as the previous claim told us that you had already discharged the member to home.
- If a patient discharges to home and then returns to your facility, you will need to bill that as a New Admission.
- All claim form coding is required to match the patient's medical records and chart notes.

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Interim billing type of bill coding

The Health Care Authority requires hospitals to bill interim claims using the appropriate patient status code 30 — Still a Patient or Expected to Return for Outpatient Services in 60-day intervals unless the patient is discharged prior to the next 60 days. Hospitals must bill each interim billed claim as an adjustment to the previous interim billed claim and must include all of the following:

- The entire date span between the patient's admission date and the current date of service billed
- All inpatient hospital services provided for the date span billed
- All applicable diagnosis codes and procedure codes for the date span billed

Billing for administrative days is an exception to the interim billing claim policy. Amerigroup may retrospectively review interim billed claims to verify medical necessity of inpatient level of care and continued inpatient hospitalization.

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Interim billing type of bill coding (cont.)

Residential treatment facilities and skilled nursing facilities are an exception to the Washington Health Care Authority *Inpatient Interim Billing Guidelines*.

Type of bill coding examples:

- 0112 — First claim paired with patient discharge status code 30
- 0113 — Each subsequent claim paired with patient discharge status code 30
- 0114 — Last claim coded paired with the discharge status code that matches the medical records and location in which the patient was released

When necessary:

- 0117 — Replacement/corrected claim with corresponding discharge status code — We will cover more detail on corrected claim submission in a later slide.

All claim form coding is required to match the patient's medical records and chart notes.

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How the type of bill and discharge status work together

An inpatient stay admit through discharge TOB 111 requires a discharge status code of the next location the patient will be presenting to. It would not be appropriate to utilize a Discharge Code 30 —Still a Patient in this scenario because your third digit is telling us that you have discharged the patient.

- First digit – 1-Hospital
- Second digit – 1-Inpatient
- Third digit – 1-Admit through Discharge

All claim form coding is required to match the patient's medical records and chart notes.

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CMS-1450 UB-04 revenue codes

Use the revenue code that best describes the patient's location within your facility. Be sure to review your Amerigroup and provider contract to validate the revenue coding that is being submitted is accurately reflecting your contract terms.

Example:

Revenue code	**Description**	**Type of room**
114	PSYCHIATRIC	PSYCH/PVT
124	PSYCHIATRIC	PSTAY/2BED
134	PSYCHIATRIC	PSYCH/3&4BED
144	PSYCHIATRIC	PSYCH/DLX
154	PSYCHIATRIC	PSYCH/WARD

The revenue coding on the claim form should match with the type of room and beds that the patient has been located in during the inpatient stay.

HCA inpatient and outpatient revenue code grid effective July 2015:

https://www.hca.wa.gov/billers-providers-partners/forms-and-publications?combine=Revenue%20code%20grid&field_topic_tid=All&field_billers_document_type_value_1=All&sort=filename%20DESC

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CMS-1450 UB-04 substance use disorder revenue codes with required HCPCS code

- Substance use disorder (SUD) Inpatient billing per the *SERI Guidelines* requires a paring of specific revenue codes with HCPCS codes for claims payment under the SUD benefit.
- Claims submitted for inpatient SUD service will require both code sets on the claim line. When the revenue code is billed without the corresponding HCPCS code, the claim will be denied.
- Inpatient billing is suggested to list a single claim line for the revenue code and HCPCS combination with the total units on one claim line.
- When each date of service is billed on a separate claim line, that can cause the claims to pend for additional review. For a faster claim processing turn around time, a single claim line submission with all days/units on one line will allow the claims system to auto-adjudicate.

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Service encounter reporting instructions guidance for revenue code and HCPCS pairing

Code	CPT/HCPCS Definition	UN / MJ	Mod	Provider Type	Service Criteria
REVENUE CODE: 1002 or 01x6 HCPC CODE: H0010	Alcohol/drug services; subacute detox in Free Standing E&T facility, per diem (inpatient residential addition program)	UN (1) (1= a day; 1 or more)	HD HZ U5	Billing Provider NPI and Taxonomy	Use this code for Clinically Managed Withdrawal Management.
REVENUE CODE: 1002 or 01x6 HCPC CODE: H0010	Alcohol/drug services; subacute detox in hospital setting, per diem (inpatient residential addition program)	UN (1) (1= a day; 1 or more)	HD HZ U5	Billing Provider NPI and Taxonomy	Use this code for Clinically Managed Withdrawal Management.
REVENUE CODE: 1002 or 01x6 HCPC CODE: H0011	Alcohol/drug services; acute detox in Free Standing E&T facility, per diem (inpatient residential addition program)	UN (1) (1= a day; 1 or more)	HD HZ U5	Billing Provider NPI and Taxonomy	Use this code for Medically Monitored Withdrawal Management.
REVENUE CODE: 1002 or 01x6 HCPC CODE: H0011	Alcohol/drug services; acute detox in hospital setting, per diem (inpatient residential addition program)	UN (1) (1= a day; 1 or more)	HD HZ U5	Billing Provider NPI and Taxonomy	Use this code for Medically Monitored Withdrawal Management.

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Single claim line versus multiple lines per date of service billing

Example 1 — Clean claim

The inpatient revenue code claim line best practice billing is to complete a single claim line with the first date of service of the stay and/or portion of the stay for interim bills in *UB-04* box 45.

42 REV CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1002		H0018	07/31/19	15	15000.00	0.00	

Example 2 — Daily charges split

When the revenue code billing is split out to bill one day per claim line, this can cause the claim processing system to pend for claim processor review. Thus delaying the claim processing turnaround time.

42 REV CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1002		H0018HV	01/31/19	1	183.36	0.00	
1002		H0018HV	02/01/19	1	183.36	0.00	
1002		H0018HV	02/02/19	1	183.36	0.00	
1002		H0018HV	02/03/19	1	183.36	0.00	
1002		H0018HV	02/04/19	1	183.36	0.00	

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Behavioral health versus SUD ICD-10-CM coding and coverage

The revenue codes, CPT®/HCPCS and diagnosis codes on a claim tell the story of the treatment the patient received, the treatment dates and why the patient needed the treatment.

An example of a billing error:

A claim is submitted indicating that a patient received an *alcohol/drug assessment* (HCPCS code H0001) and the reason given for why the assessment was needed is *major depressive disorder, recurrent, moderate* (diagnosis code F33.1). This claim will deny because F33.1 does not indicate a substance use disorder and, therefore, does not support the treatment coded.

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Behavioral health versus SUD ICD-10-CM coding and coverage (cont.)

The current trending denials of *service not covered* is in large part due to this mismatch of behavioral health and SUD services pairing with the primarily ICD-10-CM coding.

Due to the various, specific ICD-10-CM coding requirements for reimbursement of services, always be sure to review your contract terms as well as the appropriate billing guidelines.

All claim form coding is required to match the patient's medical records and chart notes.

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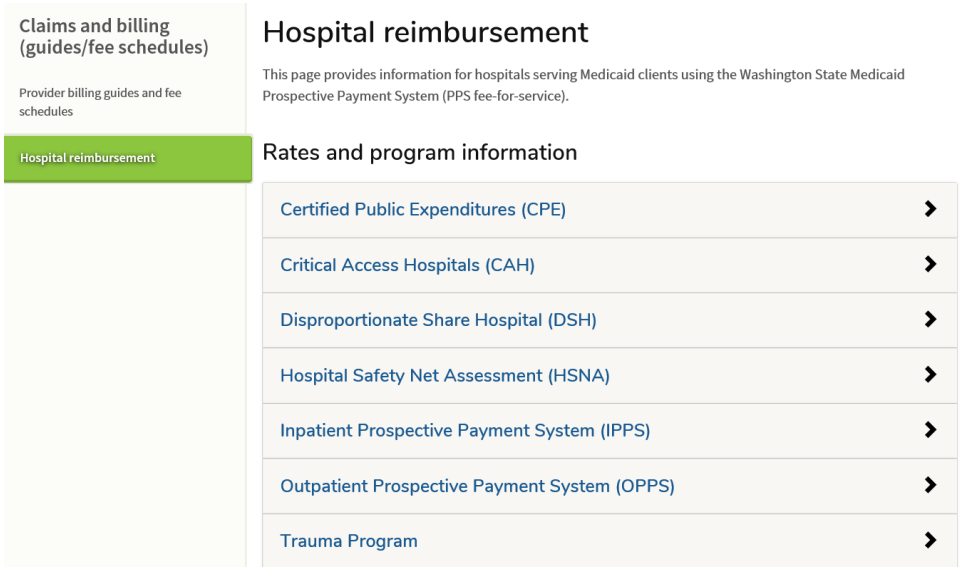
ProviderOne *Billing and Resource Guides*

The ProviderOne *Billing and Resource Guides* supply in-depth billing details as well as inpatient payment methodology rates with the coordinating hospital types.

Fee schedule (reimbursement/rates) — See Inpatient Prospective Payment System (IPPS) on the hospital reimbursement page.



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Service Encounter Reporting Instructions (SERI)

The Service Encounter Reporting Instructions (SERI) provide assistance for reporting behavioral health service encounters. SERI offers this assistance to:

- Apple Health managed care organizations (MCOs)
- Behavioral Health Administrative Services Organizations (BH-ASO) in integrated care regions
- All behavioral health providers in licensed community mental health clinics/licensed behavior health agencies

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Service Encounter Reporting Instructions (SERI) (cont.)

The manual is divided into sections describing: service eligibility, when to report services, what encounters to report, general reporting instructions, guidelines for record documentation, and service and program descriptions. Service description pages include the definition of the service, staff qualifications, provider types, guidelines, and the CPT/HCPCS code for service description. Program pages include a brief description of the program, guidelines for inclusions, exclusions, and any additional services available for specific programs.

The SERI guide provides billing specific details that are necessary for behavioral health as well as substance use disorder services.

https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri

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Corrected claims submission details and resources

Amerigroup provider homepage

- https://provider.amerigroup.com/wa

Provider Manual

- https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf

Corrected Claim Correspondence Form

- https://providers.amerigroup.com/ProviderDocuments/OHOH_ClaimCorrespondenceForm.pdf

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Corrected claims submission details and resources (cont.)

Provider Manual — Corrected Claims – page 114
When submitting a correction for a previously billed claim on a *CMS-1450* form, include all services on the new submission. If any previously submitted changes or services are not billed on the corrected claim form, they will be removed in the adjustment.

Any reduction in payment amount would result in a negative account balance and/or a refund request. Amerigroup does not accept individual lines for correction on a *CMS-1450* form.

Standard timely filing guidelines apply to all corrected and replacement claims.

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Corrected claims submission details and resources (cont.)

Need to submit a corrected claim due to errors or changes on original submission

Submit a *Claim Correspondence Form* and your corrected claim to:
Claims Correspondence
Amerigroup Washington, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Standard timely filing guidelines apply to all corrected and replacement claims.

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Corrected claims submission details and resources (cont.)

Please reference your contract for timely filing standards. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *Explanation of Payment* (*EOP*).

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Amerigroup resources

Amerigroup provider website: https://provider.amerigroup.com/wa

Availity* Portal
https://apps.availity.com/availity/web/public.elegant.login?source=MBU

Amerigroup contact information:
Provider Services (general inquiries regarding claims, prior authorizations, etc.):
1-800-454-3730

Electronic Data Interchange Hotline (electronic claim submission questions/issues):
1-800-590-5745

Direct credentialing submissions or inquiries to WACredentialing@Amerigroup.com.

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Amerigroup resources (cont.)

Provider roster submission: waopsrequest@amerigroup.com

Confirm prior authorization requirements: https://providers.amerigroup.com/Pages/PLUTO.aspx

Critical Incident reporting: QMNotification@Anthem.com

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Health Care Authority resources

1. Service Encounter Reporting Instructions (SERI): https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri
2. ProviderOne: https://www.waproviderone.org/
3. ProviderOne Billing and Resource Guide: https://www.hca.wa.gov/billers-providers-partners/providerone/providerone-billing-and-resource-guide
4. Washington Health Care Authority provider billing guides and fee schedules: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules
5. Paper claim billing resource: https://www.hca.wa.gov/assets/billers-and-providers/paper-claim-billing-resource.pdf
6. WiSe Manual: https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf

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Questions

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