Appendix H-1

Explanation of Information on Provider Information Sheet

The Provider Information Sheet is produced when a provider is enrolled in the department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date the signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic H-201.5 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any department forms.

The following information will appear on the Provider Information Sheet.

Field	Explanation
Provider Key	This number uniquely identifies the provider, and is used internally by the department. It is linked to the reported NPI(s).
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the department's records. The three-digit **County** code identifies the county where the hospital is located. It is also used to identify a state if the hospital's location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information reflecting the manner in which the provider is enrolled with the department. **Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification.

Organization Type is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Sole Proprietary
02 = Partnership
03 = Corporation

Enrollment Status is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the department's Medical Programs. Cost report requirements are also indicated. The possible codes are:

A = Active, Cost Report Required
B = Active, Cost Report Not Required
I = Inactive
N = Non Participating

Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in the department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field.

Exception Indicator may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Intent to Terminate
B = Expired License
C = Citation to Discover Assets
D = Delinquent Child Support
E = Provider Review
F = Fraud Investigations
G = Garnishment
I = Indictment
L = Student Loan Suspensions
R = Intent to Terminate/Recovery
S = Exception Requested by Provider Participation Unit
T = Tax Levy
X = Tax Suspensions

If this item is blank, the provider has no exception.

	Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.
Medicare Number	This is the number that the Medicare processing agency uses to identify the hospital.
Categories of Service	This area identifies the types of service a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the department's Medical Programs. Each entry is followed by the date on which the provider was approved to render services for each category listed. Since there are multiple categories of services for which a general, psychiatric, or rehabilitation hospital may enroll, refer to the instructions for the Provider Enrollment Application (HFS 2243), which defines all applicable categories of services.
Payee Information	This area records the name and address of the entity authorized to receive payments on behalf of the hospital. The payee is assigned a single-digit **Payee Code.** **Payee ID Number** is a sixteen-digit identification number assigned to each payee, for whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore, no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.
NPI	The National Provider Identification Number contained in the department's database.
Signature	The provider is required to affix an original signature when submitting charges to the Department of Healthcare and Family Services.

Appendix H-1a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 12/16/09
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 12/16/09
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
0000111111111

PROVIDER NAME AND ADDRESS

COUNTY 089-SCOTT
TELEPHONE NUMBER

RE-ENRL IND: N DATE: 11/15/86

PROVIDER TYPE: 030 – GENERAL HOSPITAL
ORGANIZATION TYPE: 03 – CORPORATION
ENROLLMENT STATUS A – ACTIV CST BEGIN 11/15/86 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – ENDING
CLIA #:
LAST TRANSACTION ADD AS OF 04/21/97 MEDICARE #
FACILITY CTL/AFFIL:
FISCAL YEAR END: PSYCH BED COUNT: ACUTE BED COUNT:

INSTUTION INFORMATION:

INSTITUTION BED CNT: INST BED: BEGIN 02/01/99

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1								

DBA: VENDOR ID: 01

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
XXXXXXXXXX

********** PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE X

Appendix H-2

UB-04 Requirements for HFS Adjudication of Inpatient, Outpatient, and Renal Dialysis Claims

Instructions for completion of this form follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. **For detailed form locator information, all providers should have a copy of the UB-04 Data Specifications Manual for reference.** To become a UB-04 Subscriber, refer to the National Uniform Billing Committee (NUBC) Web site. The UB-04 Data Specifications Manual contains a blank facsimile of the UB-04. Providers may also view a UB-04 facsimile on the department's Web site. For billing purposes, providers must still submit an original UB-04.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional – In some cases failure to include an entry will result in certain assumptions by the department and will preclude corrections of certain claiming errors by the department.
Conditionally Required	=	Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Appendix H-2a

Completion	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
=Conditionally Required *Revised October 2010 – Effective October 2010*	**2.**	**Pay-To Name and Address -** Effective with claims received August 1, 2009, through September 30, 2010, HFS allowed a dual process for reporting the payee. The dual process period allowed providers to transition from using the one-digit payee code to using the Pay-To Provider (Payee) NPI. **For claims received on and after October 1, 2010, the department will only accept the Pay-To Provider (Payee) NPI.** Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
Optional	**3a.**	**Patient Control Number**
Optional	**3b.**	**Medical Record Number**
Required	**4.**	**Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.
Optional	**5.**	**Fed. Tax No.**
Required	**6.**	**Statement Covers Period**
Conditionally Required	**10.**	**Patient Birth Date** - If a birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If a birth date is not entered, the department will not attempt corrections. A birth date is required only if the claim contains a Type of Admission 4 (newborn).

Required **12. Admission Date**

Conditionally Required **13. Admission Hour –** An admission hour is required only if the Type of Bill Frequency Code is 1 or 2.

Required **14. Priority (Type) of Visit**

Conditionally Required **15. Source of Referral for Admission -** Code 4 or D is required when a patient is transferred from another hospital or transferred from hospital inpatient in the same facility, resulting in a separate claim to the payer.

Required **17. Patient Discharge Status**

Conditionally Required **18-28. Condition Codes -** Required if a condition code applies to this claim, such as C1, C3, AJ, or applicable abortion codes.

Conditionally Required **31-34. Occurrence Codes and Dates –** Refer to the UB-04 Data Specifications Manual for usage requirements.

Conditionally Required **35-36. Occurrence Span Code/From/Through** – When reporting non-covered days, providers must indicate the non-covered date span.

Required **39-41. Value Codes** – Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter.

Value Code 80 is required for all inpatient claims (the number of days covered by the primary payer). The other value codes below are conditionally required based upon the particular claim.

Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim.

Value Code 81 – The number of days of care not covered by the primary payer.

Value Codes applicable to Medicare deductible or coinsurance due.

Required **42. Revenue Code –** Enter the appropriate revenue code for the service provided. The 23rd Revenue Line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

Required **43. Revenue Description**

Required **44. HCPCS/Accommodation Rates** – For accommodation revenue codes, dollar values reported must include whole dollars, the decimal, and the cents.

Required **46. Service Units –** For each accommodation revenue code, enter the total number of covered days associated with that revenue code. If there are no covered days associated with an accommodation revenue code, the hospital must still enter a "0" (zero) in this field.

Required **47. Total Charges** (By Revenue Code category)
For Revenue Code 0001, see FL 42 above.

Conditionally Required **48. Non-Covered Charges** – Reflects any non-covered charges pertaining to the related revenue code.

Required **50. Payer** - Illinois Medicaid or 98916 must be shown as the payer of last resort.

Conditionally Required

51. Health Plan Identification Number

HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field, until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. This is required if there is a third party source.

TPL Code – If the patient's medical card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9.

Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:
01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.
02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
08 – Estimated Payment: TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.
10 – Deductible Not Met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.
99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.

Conditionally Required

54A,B. Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.

Required

56. National Provider Identifier – Billing Provider
Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.

Optional

57. Other (Billing) Provider Identifier
Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.

Required

58. Insured's Name – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the department.

Required

60. Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do **not** use the Case Identification Number.

Conditionally Required

64. Document Control Number – At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.

Required

67. Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD 9-CM code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8th position shaded area. If the POA indicator is not placed in the shaded areas noted, it will be captured as part of the diagnosis code, which may cause the claim to be rejected.

Conditionally Required

67A-Q. Other Diagnosis Codes
Enter the specific ICD 9-CM code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8th position shaded area.

Required

69. Admitting Diagnosis Code – Enter the specific ICD 9-CM code without the decimal.

Conditionally Required

72A-C. External Cause of Injury (ECI) Code – The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

Conditionally Required

74. Principal Procedure Code and Date - Required if a procedure is performed.

Conditionally Required

74a-e. Other Procedure Codes and Dates – Required if there were any additional procedures performed.

= Required
Effective August 2011

76. Attending Provider Name and Identifiers
For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI.

=Conditionally Required
Effective August 2011

77. Operating Physician Name and Identifiers – Required if a surgical procedure is performed. For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI.

=Conditionally Required
Effective August 2011

78-79. Other Provider (Individual) Names and Identifiers – For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI. Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.

Required

81. Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Chapter 300, Handbook for Electronic Processing, available on the department's Web site. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

***Additional notes**

Form Locator 80 Remarks – HFS utilizes this field to assign each claim's unique Document Control Number. Providers do not utilize this field.

Appendix H-2b

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient, Outpatient Rehabilitation, and Outpatient Psychiatric Claims
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
=Conditionally Required *Revised October 2010 – Effective October 2010*	**2.**	**Pay-To Name and Address** – Effective with claims received August 1, 2009, through September 30, 2010, HFS allowed a dual process for reporting the payee. The dual process period allowed providers to transition from using the one-digit payee code to using the Pay-To Provider (Payee) NPI. **For claims received on and after October 1, 2010, the department will only accept the Pay-To Provider (Payee) NPI.** Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
Optional	**3a.**	**Patient Control Number**
Optional	**3b.**	**Medical Record Number**
Required	**4.**	**Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.
Optional	**5.**	**Fed. Tax No.**
Required	**6.**	**Statement Covers Period**
Optional	**10.**	**Patient Birth Date** - If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the department will not attempt corrections.

Conditionally Required

18-28. Condition Codes – Claims containing an abortion procedure need a corresponding abortion condition code.

Conditionally Required

35-36. Occurrence Span Code/From/Through – When reporting non-covered days, providers must indicate the non-covered date span.

Conditionally Required

39-41. Value Codes – The value codes below are conditionally required based upon the particular claim. Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter.

Value Code 24 – Required for Medicare crossover claims to identify the number of departments visited. The department multiplies the reimbursement rate by the total departments visited during the billing period to arrive at the department allowable amount. A department is defined as a group of 10 revenue codes; for example, Revenue Codes 270 through 279 would be considered one department. If total units are not indicated on the UB, the calculation will be made using one unit.

Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim.

Value Code 80 – The number of covered days is required for series claims.

Value Codes applicable to Medicare deductible or coinsurance due.

Required

42. Revenue Code – Enter the appropriate revenue code for the service provided. The 23rd Revenue Line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

Required

43. Revenue Description - Refer to the UB-04 Manual for details.

NDC reporting of certain injectable drugs associated with Revenue Line 0636 is required. The expensive drugs that require NDC reporting are referenced on the department's Web site.

- Report the N4 qualifier in the first two (2) positions, left-justified
- Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens)
- Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier Codes are as follows:
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to three (3) digits (to the right of the decimal).
- Any spaces unused for the quantity are left blank.

Required

44. HCPCS/Accommodation Rates – Claims containing emergency, observation, or psychiatric department services must identify specific procedure codes. Refer to the final page of the APL Group Order List on the Web site.

Optional

45. Service Date – If a date is entered, it will be edited.

Conditionally Required

46. Service Units – Claims for the following services must contain an entry:

- Observation claims must contain the number of hours of observation.
- Claims containing an expensive drug, as identified on the department's Web site and associated with Revenue Code 0636, must contain the number of units given.
- Series claims for series-billable revenue codes must contain an entry that is at least equal to the number of Covered Days.

Required

47. Total Charges (By Revenue Code category)
For Revenue Code 0001, see FL 42 above.

Conditionally Required

48. Non-Covered Charges – Reflects any non-covered charges pertaining to the related revenue code.

Required

50. Payer - Illinois Medicaid or 98916 must be shown as the payer of last resort

Conditionally Required

51. Health Plan Identification Number – HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. Required if there is a third party source.
TPL Code –If the patient's medical card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9.
Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:
01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.
02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
08 – Estimated Payment: TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.
10 – Deductible Not Met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.
99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.

Conditionally Required

54A,B. Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.

Required

56. National Provider Identifier – Billing Provider
Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.

Optional

57. Other (Billing) Provider Identifier
Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.

Required

58. Insured's Name – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the department.

Required

60. Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do **not** use the Case Identification Number.

Conditionally Required

64. Document Control Number – At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.

Required

67. Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD 9-CM code without the decimal. The POA indicator is **not** required for outpatient claims.

Conditionally Required

67A-Q. Other Diagnosis Codes - Enter the specific ICD 9-CM code without the decimal. The POA indicator is **not** required for outpatient claims.

Conditionally Required

72A-C. External Cause of Injury (ECI) Code – The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

=Required
Effective August 2011

76. Attending Provider Name and Identifiers - For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI.

=Conditionally Required
Effective August 2011

77. Operating Physician Name and Identifiers – Required if a surgical procedure is performed. For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI.

=Conditionally Required
Effective August 2011

78-79. Other Provider (Individual) Names and Identifiers – For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI. Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.

Required

81. Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Chapter 300, Handbook for Electronic Processing, available on the department's Web. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

***Additional notes**

FL 80 - Remarks – HFS utilizes this field to assign each claim's unique Document Control Number. Providers do not utilize this field.

Appendix H-2c

Completion	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
=Conditionally Required *Revised October 2010 – Effective October 2010*	**2.**	**Pay-To Name and Address** – Effective with claims received August 1, 2009, through September 30, 2010, HFS allowed a dual process for reporting the payee. The dual process period allowed providers to transition from using the one-digit payee code to using the Pay-To Provider (Payee) NPI. **For claims received on and after October 1, 2010, the department will only accept the Pay-To Provider (Payee) NPI.** Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
Optional	**3a.**	**Patient Control Number**
Optional	**3b.**	**Medical Record Number**
Required	**4.**	**Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.
Optional	**5.**	**Fed. Tax No.**
Required	**6.**	**Statement Covers Period**
Optional	**10.**	**Patient Birth Date** - If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the department will not attempt corrections.

Required

18-28. Condition Codes - Identify the dialysis place of service. The department recognizes the following codes: 71-72, 74-76

Conditionally Required

35-37. Occurrence Span Code/From/Through – When reporting non-covered days, providers must indicate the non-covered date span.

Conditionally Required

39-41. Value Codes - The value codes below are conditionally required based upon the particular claim. Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter.

Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim.

Value Code 68 – Epogen must be reported using Value Code 68.

Value Code 80 – The number of covered days is required for series claims.

Value Codes applicable to Medicare deductible or coinsurance due.

Required

42. Revenue Code – Enter the appropriate revenue code for the service provided. The 23rd Revenue Line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

Required

43. Revenue Description
For Revenue Lines 0634 and 0635: Providers must report the National Drug Code (NDC) associated with the injectable drug Epogen.

For Revenue Line 0636: Providers must report the NDC if the drug is one of those renal dialysis injectable drugs referenced on the department's Web site.

Providers also must report the NDC if the drug is one of those expensive drugs referenced on the department's Web site.

- Report the N4 qualifier in the first two (2) positions, left-justified
- Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens)
- Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to three (3) digits (to the right of the decimal).
- Any spaces unused for the quantity are left blank.

Required

44. HCPCS/Accommodation Rates – Enter the corresponding HCPCS code associated with Revenue Lines 0634, 0635, or 0636.

Optional

45. Service Date - If a date is entered, it will be edited.

Conditionally Required

46. Service Units – For a series claim, an entry is required to correspond to the renal dialysis revenue code. Also, an entry is required for claims containing Revenue Codes 0634 and 0635 for Epogen, or Revenue Code 0636 for specified renal dialysis injectable drugs or specified expensive drugs.

Required

47. Total Charges (By Revenue Code category)
For Revenue Code 0001, see FL 42 above.

Conditionally Required

48. Non-Covered Charges – Reflects any non-covered charges pertaining to the related revenue code.

Required

50. Payer - Illinois Medicaid or 98916 must be shown as the payer of last resort

Conditionally Required

51. Health Plan Identification Number – HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. Required if there is a third party source.

TPL Code –If the patient's medical card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9.
Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:
01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.
02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
08 – Estimated Payment: TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.
10 – Deductible Not Met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.
99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.

Conditionally Required

54A-B. Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.

Required

56. National Provider Identifier – Billing Provider
Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.

Optional

57. Other (Billing) Provider Identifier
Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.

Required

58. Insured's Name – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the department.

Required

60. Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do **not** use the Case Identification Number.

Conditionally Required

64. Document Control Number – At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.

Required

67. Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD 9-CM code without the decimal. The POA indicator is **not** required for renal dialysis claims.

Conditionally Required

67A-Q. Other Diagnosis Codes - Enter the specific ICD 9-CM code without the decimal. The POA indicator is **not** required for renal dialysis claims.

Conditionally Required

72A-C. External Cause of Injury (ECI) Code – The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

=Required
Effective August 2011

76. Attending Provider Name and Identifiers - For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI.

=Required
Effective August 2011

78-79. Other Provider (Individual) Names and Identifiers - For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI. Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.

Required

81. Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Chapter 300, Handbook for Electronic Processing, available on the department's Web site. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

***Additional notes**

FL 80 - Remarks – HFS utilizes this field to assign each claim's unique Document Control Number. Providers do not utilize this field.

Appendix H-2d

Mailing Instructions

The provider is to submit an original UB-04 form to the department. The pin-feed guide strip should be detached from the sides of continuous feed forms. A copy of the claim is to be retained by the provider.

UB-04 paper claims should be sent to the applicable post office box as follows:

UB-04 Claims Without Attachments:

Illinois Department of Healthcare and Family Services
UB-04 Inpatient/Outpatient Invoices
P.O. Box 19132
Springfield, Illinois 62794-9132

UB-04 Claims With Attachments:

Illinois Department of Healthcare and Family Services
UB-04 Inpatient/Outpatient Invoices
P.O. Box 19133
Springfield, Illinois 62794-9133

UB-04 Claims Requiring Special Handling by the Billing Consultants:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
P.O. Box 19128
Springfield, Illinois 62794-9128

Adjustments (Form HFS 2249):

Illinois Department of Healthcare and Family Services
Hospital Adjustment Unit
P.O. Box 19128
Springfield, Illinois 62794-9101

Forms Requisition:

The department does not supply the UB billing form. Adjustment forms may be requested on the Web site or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

Appendix H-2e

Billing Scenarios

This appendix contains examples of various types of hospital services that may be submitted to the department. Particular form locators affected and instructions for completion are identified with each scenario. Hospitals still need to reference Appendix K-2, Required Fields.

The following billing scenarios pertain only to institutional claims. Ambulatory Procedures Listing (APL) policy does allow a fee-for-service claim to be submitted under the name and NPI of one salaried physician involved in direct patient care. This fee-for service claim may be billed in addition to the outpatient APL claim. For detailed information regarding APL, refer to the Handbook for Hospitals, Topic H-270, Ambulatory Services.

Billing Scenario 1
Inpatient Medicare/Medicaid Combination Claim ("Crossover")

The patient was admitted to the hospital on June 15, 20XX and discharged on June 22, 20XX. This patient has Medicare Part A and B coverage as well as Illinois Medicaid coverage. The provider is billing for the Medicare Part A deductible.

FL 39-41 – Value Codes. Enter Value Code A1 and the Medicare deductible amount due. (In a case when the coinsurance, not deductible, is due, enter Value code A2).

FL 50, Line A – Payer Name. Enter "Medicare." Illinois Medicaid is listed after all other payers.

FL 51, Line A – Health Plan ID. Enter "909," the department's legacy three-digit TPL code for Medicare Part A; a space; and then two-digit TPL status code "01."

FL 54, Line A – Prior Payment. Enter the net reimbursement amount from Medicare.

Billing Scenario 2
Inpatient Claim with Medicare Part B and Medicaid Coverage

The patient was admitted as an inpatient on February 17, 20XX. On February 19th, the patient was transferred to another larger general inpatient facility. The patient has Medicare Part B only coverage, as well as Illinois Medicaid coverage.

FL 4 – Type of Bill. For inpatient Part B only claims, enter "0121."

FL 22 – Discharge Status – "02" (transferred to another short term hospital.)

FL 50, Line A – Enter "Medicare." Illinois Medicaid is listed after all other payers.

FL 51, Line A - Enter "910," the department's legacy three-digit TPL code for Medicare Part B; a space; and then two-digit TPL status code "01."

FL 54, Line A – Prior Payments. Enter the net reimbursement amount from Medicare Part B.

Billing Scenario 3
Inpatient Claim with Third Party Liability (TPL)

The patient was admitted to the hospital on May 18, 20XX and discharged on May 21, 20XX. The patient has Blue Cross/Blue Shield insurance that paid toward her hospital stay, and also Illinois Medicaid coverage.

FL 50, Line A – Payer. Enter "Blue Cross/Blue Shield." Illinois Medicaid is listed after all other payers.

FL 51, Line A - Enter the appropriate legacy three-digit TPL code for Blue Cross/Blue Shield; a space; and then two-digit TPL status code "01."

FL 54, Line A – Prior Payment. Enter the actual payment received from the third party payer.

Billing Scenario 4
Inpatient Admission with Non-Covered Days

The patient was admitted on November 12, 20XX and discharged the following January 6, 20XX. Effective January 1, the patient was not eligible for Illinois Medicaid.

FL 6 – Statement Covers Period. Enter the actual admission through discharge dates.

FL 18-28 – Condition Codes. Enter "C3."

FL 35-36 – Occurrence Span. Line A, enter code "74" with the non-covered date span that must equal the number of non-covered days billed.

FL 39-41 – Value Codes. Enter Value Code 80 with the number of covered days (50.) Enter Value Code 81 with the number of non-covered days (5.) The date of discharge is not counted as a non-covered day.

FL 46 – Service Units. Enter units for the covered accommodation days.

FL 47 – Total Charges. List the total charges for the entire admission.

FL 48 – Non-covered Charges. Indicate charges for the non-covered days, as well as any other non-covered charges.

Billing Scenario 5
Inpatient Transfer from General Care to Psychiatric Care

The patient was admitted on March 2, 20XX for a medical condition and was transferred to the psychiatric unit on March 7th. The patient was discharged on March 15th. Two UB-04 invoices will be required.

Medical Claim:

FL 4 – Type of bill. Enter "0111" (admission through discharge claim.)

FL 6 – Statement Covers Period. Enter the admit date through the transfer date.

FL 12 – Admission Date. Enter the actual date the patient was admitted to the hospital.

FL 17 – Patient Discharge Status. Must use discharge status "65."

FL 67 – Principal Diagnosis Code. Enter the principal diagnosis for the medical problem.

Psychiatric Claim:

FL 4 – Type of Bill. Enter "0111" (admission through discharge claim.)

FL 6 – Statement Covers Period. Enter the date the patient transferred to psychiatric care through the discharge date.

FL 12 – Admission Date. Enter the date the patient was transferred from general care to psychiatric care.

FL 17 – Patient Discharge Status. Enter actual discharge status for the psychiatric stay.

FL 67 - Principal Diagnosis Code. Enter the principal diagnosis for the psychiatric illness.

Billing Scenario 6
Medicare Part A Exhaust During Inpatient Stay

The patient has Medicare Part A and B. He was admitted to the hospital on March 10, 20XX and was discharged on June 24, 20XX. His Part A benefits exhausted on June 3, 20XX.

Two claims will be required for this inpatient stay.

Claim 1: Medicare Claim

FL 4 – Type of Bill. Enter "0111."
FL 6 – Statement Covers Period. This patient was eligible for Medicare Part A from 031020XX through 060320XX.
FL 39-41 – Value Codes. Enter Value Code 80 – Covered Days and the number of days (85 days). Enter Value Code A2 and the coinsurance amount due.
FL 46 – Service Units. Enter 85 covered accommodation days.
FL 47 – Total Charges. Enter the total charges for the 85 covered days.
FL 50, Line A – Payer. Medicare is the primary payer.
FL 51, Line A – Health Plan ID. Enter "909," the department's legacy three-digit TPL code for Medicare Part A; a space; and then two-digit TPL status code "01."
FL 54, Line A – Prior Payment. Enter the net reimbursement amount from Medicare.

Claim 2: Medicaid Claim

FL 4 – Type of Bill. Enter "0121."
FL 6 – Statement Covers Period. Enter the actual date of admission through the discharge date (March 10, 20XX through June 24, 20XX).
FL 18-28 - Condition Codes. Enter a "C1."
FL 35-36 – Occurrence Span. Line A, enter code "74" with the non-covered date span that must equal the number of non-covered days listed as Value Code 81.
FL 39-41 – Value Codes. Enter Value Code 80 – Covered Days and the number of days under the Medicaid coverage (21 days). Enter Value Code 81 – Non-covered Days and the number of days that were covered under Medicare (85 days).
FL 46 – Service Units. Enter the number of covered accommodation days.
FL 47 – Total Charges. Total charges for all 106 days of care.
FL 48 – Non-covered Charges. Enter charges for the non-covered days of care, plus any other non-covered charges.
FL 50, Line A – Payer. Medicare is the primary payer.
FL 51, Line A – Health Plan ID. Enter "910," the department's legacy three-digit TPL code for Medicare Part B; a space; and then two-digit TPL status code "01."
FL 54, Line A – Prior Payment. Enter the net reimbursement amount from Medicare Part B.

Note: The Medicaid claim requires a manual override and must be submitted to the billing consultant.

Billing Scenario 7
Medicare HMO Inpatient Crossovers for Disproportionate Share

The patient has medical coverage under a Medicare HMO, as well as Illinois Medicaid. This patient was admitted on July 16, 20XX and was discharged on July 20, 20XX. The Medicare HMO covered the inpatient stay and the department has no liability for this claim, but the department allows these inpatient days to be counted as part of the hospital's disproportionate share calculation. The hospital should submit a Medicare crossover claim, paying special attention to the form locators noted.

FL 18 – Condition Codes. Enter condition code "04" (Information Only Bill).

FL 39-41 – Value Codes. Enter value code A1 with an associated amount of "0.00."

Aside from the additional information above, claim preparation and submittal for these claims is the same as for other Medicare/Medicaid combination claims; i.e., the payer name must be listed as "Medicare," and the TPL code "909" for Medicare Part A and the Medicare HMO payment amount must be present.

Billing Scenario 8
Late Ancillary Charges

A hospital submitted an inpatient claim for dates of service June 5, 20XX through June 8, 20XX. The claim was approved and paid by Illinois Medicaid. The hospital then discovered that a $275.00 pharmacy charge was omitted from the bill. This claim will be submitted to identify the undercharge from the original claim. It will not affect the payment from the original claim.

FL 4 – Type of Bill. The frequency digit (fourth digit) must be a "5."

FL 6 – Statement Covers Period. Enter the actual admission through discharge dates.

FL 42 – Revenue Codes. Enter **only** the revenue code that identifies the missing ancillary service.

FL 47 – Total Charges. Enter the charges missing from the original claim.

Note: If the missing charges would affect the payment, the provider must void the original claim and rebill.

Billing Scenario 9
Inpatient Claim Selected for Retrospective Prepayment

The patient was admitted on July 8, 20XX and was discharged on July 14, 20XX. The claim met the criteria for selection for retrospective prepayment review. The department's Quality Improvement Organization (QIO) denied the days of July 12th and July 13th as not medically necessary. The QIO sent the hospital an advisory notice informing them of the denied days.

FL 39-41 - Value Codes. The claim must be coded according to the QIO Advisory Notice. In this case, enter Value Code 81 and the number of non-covered days.

FL 35-36 – Occurrence Span. Line A, enter code "74" with the non-covered date span that must equal the number of non-covered days billed.

FL 48 – Non-covered Charges. Enter charges for the non-covered days of care, plus any other non-covered charges.

The claim must be billed as a paper UB-04 with the QIO Advisory Notice attached.

Billing Scenario 10
Inpatient Admission with Admission/Concurrent/Continued Stay Review

The patient was admitted on August 11, 20XX with a medical diagnosis requiring utilization review. The diagnosis code requires the hospital to contact the department's QIO to certify the admission and assign a length of stay. (Note: If this claim is reimbursed through the DRG reimbursement system, no length of stay will be assigned). The QIO approved the admission and a length of stay through August 16th (6 days).

FL 6 - Statement Covers Period - Enter the actual admission through discharge dates. If the patient's length of stay went beyond the date approved by the QIO, those days must be shown as non-covered.

FL 69 - Admitting Diagnosis Code – Enter the ICD-9-CM diagnosis code describing the patient's diagnosis at the time of admission. Any 4th or 5th digit code extension of a three-digit root code, approved as the admitting diagnosis code at the time of the certification of admission, will be acceptable on the claim submitted to the department. As an example, if the code supplied by the hospital to HSI at the time of the certification of admission was 585.1, but the code on the actual claim submitted was 585.2, the claim will pass through the edit.

Billing Scenario 11
Outpatient Medicare/Medicaid Combination Claim ("Crossover")

The patient has both Medicare and Medicaid coverage. She was treated at the hospital emergency room on August 8, 20XX and released.

FL 39 – 41 – Value Codes. Enter Value Code "A1" and the amount of the Medicare deductible due. (In a case when the coinsurance, not deductible, is due, enter Value Code A2). Enter value code 24 and the number of hospital departments visited for the treatment episode. For this purpose, a department is defined as a revenue code category. For example, Revenue Code Category 027X, comprised of Revenue Codes 0270 through 0279, would be considered one department. If the total number of department's visited is not indicated with the appropriate value code, the payment calculation will be made using one department.

FL 42 – Revenue Code. Enter all appropriate revenue codes.

FL 50, Line A – Payer Name. Enter "Medicare." Illinois Medicaid is listed after all other payers.

FL 51, Line A – Health Plan ID. Enter "910," the department's legacy three-digit TPL code for Medicare Part A; a space; and then two-digit TPL Status Code "01."

FL 54, Line A – Prior Payment. Enter the net reimbursement amount from Medicare.

Note: Medicare may have a deductible or coinsurance on some lab services. If a lab service has a deductible or coinsurance due, the provider may count it as a department visited.

Billing Scenario 12
Outpatient Medicare/Medicaid Combination ("Crossover") Series Claim

The patient has both Medicare and Medicaid coverage. She has already met her Part B deductible for the year. The patient received physical therapy on July 1st, July 8th, and July 15th.

FL 6 – Statement Covers Period. The From Date is the first date that patient received treatment (July 1) and the Through Date is the last date the patient received treatment (July 15) for the billing cycle. Do **not** automatically enter the beginning and ending dates of the calendar month.

FL 39-41 – Value Codes. Enter value code 80 and the total number of days the patient received treatment during the billing cycle. Enter Value Code A2 and the amount of the coinsurance due. Enter Value Code 24 and the number of hospital departments visited for the treatment span.

Example:
July 1 – 3 departments visited
July 8 – 2 departments visited
July 15 – 1 department visited

The total number of departments visited for the treatment span is six (6), which should be the corresponding entry for Value Code 24.

Billing Scenario 13
Outpatient Same Day Surgery with Spenddown

The patient received outpatient laser surgery of the eye at a local hospital on September 2, 20XX. The procedure is listed in the Ambulatory Procedures Listing (APL). No problems arose and the patient was released the same date. Total charges on the hospital claim were $3,582.00. The patient has a $276.00 Spenddown to meet monthly. The hospital's bill was used to meet the Spenddown.

FL 39-41 – Value Codes. Enter Value Code 66 and the Patient Liability Amount ($276.00) identified on the HFS 2432, Split Billing Transmittal.

FL 42 – Revenue Code. When a surgical procedure is used on a claim, Revenue Code 0360 must be identified.

FL 44 – HCPCS/Rate. Use the appropriate APL code to identify the procedure.

Note: A claim that identifies Spenddown must be billed on the UB-04 paper claim format with the HFS 2432 Split Billing Transmittal attached. See Topic H-260.23 for additional information regarding Spenddown.

Billing Scenario 14
Emergency Department with Observation and Hospital Admission

The patient presented to the emergency room with chest pains on April 6, 20XX at 5:00 A.M. After examination, he was admitted to observation at 7:00 A.M. At 3:30 P.M., he was admitted as an inpatient.

Two claims may be submitted:

1st claim – Outpatient Claim
The claim will reflect the emergency room charge or the observation room charge only. All ancillaries are to be reported on the inpatient claim.

2nd claim – Inpatient Claim
The claim will be for the inpatient admission and all ancillaries that were provided in the outpatient setting prior to admission.

Under APL policy, the services of one salaried physician may be billed fee-for service in addition to the outpatient institutional APL claim. The salaried physician claim must be billed under the name and NPI of the physician who rendered the service. See Topic H-270.21 for additional information.

If a patient is on a Spenddown case, please refer to Topic H-260.23 for information relating to the inpatient, outpatient, and fee-for-service charges to be submitted to the Family Community Resource Center (FCRC).

Billing Scenario 15
National Drug Codes (NDCs) for Outpatient Series Renal Dialysis Claim

The patient is a continuing renal dialysis patient and receives treatment at a freestanding dialysis facility. This claim is for service dates beginning July 2, 20XX through July 30, 20XX, for a total of 13 dialysis treatments. The patient received Epogen (>10, 000 units) and Iron Dextran during this period of treatment.

FL 4 – Type of Bill. The first digit in this form locator must be a "0." The second digit must be a "7." The third digit must be a "2." The fourth digit must be a "3," to identify it as an interim continuing claim.

FL 6 – Statement Covers Period. The From Date is "0702XX" and the Through Date is "0730XX." Do not automatically bill for the entire calendar month, if the patient's beginning and ending treatment dates are not the first and last dates of that calendar month.

FL 39-41 – Value Codes. Enter Value Code 68 to report Epogen. Enter Value Code 80 with the number of covered days. This patient has 13 covered days.

FL 42 – Revenue Code. Identify the appropriate revenue code for the type of dialysis utilized. Enter revenue line "0635" to denote Epogen >10,000 units. Enter revenue line "0636" to denote Iron Dextran.

FL 43 – Revenue Description. Report the following for both revenue line 0635 (for Epogen) and 0636 (for Iron Dextran):

- Report the N4 qualifier in the first two (2) positions, left- justified
- Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens)
- Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
- Any spaces unused for the quantity are left blank.

Form Locator 44 – HCPCS/Rates. Enter the corresponding HCPCS code associated with revenue lines 0635 and 0636.

Form Locator 46 – Service Units. For a series claim, an entry is required to correspond to the renal dialysis revenue code. In this case, enter "13." For revenue code 0636 for Iron Dextran, enter the number of units administered.

Billing Scenario 16
Expensive Drugs and Devices Outlier Payment

The patient received a pacemaker in the outpatient setting on July 23, 20XX. The HCPCS code for the pacemaker is on the department's Expensive Drugs and Devices Listing, located on the department's Web site. This item does not require prior approval.

FL 42 – Revenue Code. In this case, utilize Revenue Code 0275 (Pacemakers) for the pacemaker. (For claims that contain an expensive drug from the listing, utilize Revenue Code 0636; for devices, use Revenue Code 0279).

FL 44 – HCPCS/Accommodation Rates. The HCPCS code for the pacemaker must be reported across from Revenue Code 0275. The corresponding APL code can be identified on any other revenue code billed.

The Outpatient Cost Outlier Worksheet on the department's Web site can be used to calculate the amount of the additional outlier payment.

Appendix H-3
Revenue Code Information

Non-Covered Revenue Codes	
Revenue Code	**Revenue Description**
0115	Hospice/PVT
0125	Hospice/2Bed
0135	Hospice/3&4Bed
0145	Hospice/DLX
0155	Hospice/Ward
0167	Room and Board/ Self Care
0180	Leave of Absence or LOA
0182	Patient Convenience - Charges Billable
0183	Therapeutic Leave
0185	Nursing Home (for Hospitalization)
0189	Other Leave of Absence
0190	Subacute Care
0191	Subacute Care-Level I
0192	Subacute Care-Level II
0193	Subacute Care-Level III
0194	Subacute Care-Level IV
0199	Other Subacute Care
0220	Special Charges
0221	Admission Charge
0222	Technical Support Charge
0223	U.R. Service Charge
0224	Late Discharge, Medically Necessary
0229	Other Special Charges
0230	Incremental Nursing Charge Rate
0231	Nursing Increment/Nursery
0232	Nursing Increment/OB
0233	Nursing Increment/ICU
0234	Nursing Increment/CCU
0235	Nursing Increment/Hospice
0239	Nursing Increment/Other
0256	Experimental Drugs
0262	IV Therapy/Pharmacy Services
0263	IV Therapy/Drug/Supply Delivery
0264	IV Therapy Supplies

Non-Covered Revenue Codes	
0303	Laboratory / Renal Patient (Home)
0374	Anesthesia / Acupuncture
0380	Blood
0381	Blood / Packed Red Cells
0382	Blood / Whole
0383	Blood / Plasma
0384	Blood / Platelets
0385	Blood / Leucocytes
0386	Blood / Other Components
0387	Blood / Other Derivatives (Cryoprecipitate)
0389	Blood / Other
0500	Outpatient Services
0509	Other Outpatient Services
0512	Dental Clinic
0520	Free Standing Clinic
0521	Rural Health Clinic
0522	Rural Health Home
0523	Family Practice
0526	Free Standing Clinic/Urgent Care
0529	Other Free Standing Clinic
0550	Skilled Nursing
0551	Skilled Nursing / Visit Charge
0552	Skilled Nursing / Hourly Charge
0559	Other Skilled Nursing
0560	Medical Social Services
0561	Medical Social Services / Visit Charge
0562	Medical Social Services / Hourly Charge
0569	Other Medical Social Services
0570	Home Health Aide (Home Health)
0571	Home Health Aide / Visit Charge
0572	Home Health Aide / Hourly Charge
0579	Other Home Health Aide
0580	Other Visits (Home Health)
0581	Other Visits (Home Health) / Visit Charge
0582	Other Visits (Home Health) / Hourly Charge
0589	Other Visits (Home Health) / Other
0590	Units Of Service (Home Health)
0600	Oxygen/General Classification (Home Health)

Non-Covered Revenue Codes	
0601	Oxygen-Stat Equipment
0602	Oxygen-Stat. Equip
0603	Oxygen-Stat. Equip
0604	Oxygen-Portable Add-On
0624	FDA Invest Devices
0631	Single Source Drug
0632	Multiple Source Drug
0633	Restrictive Prescription
0637	Drugs / Self Admin
0640	Home IV Therapy
0641	Home IV Non-Routine
0642	IV Site Care
0643	IV Start
0644	Non-Routine Nursing
0645	Training-Patient
0646	Training-Disabled Patient
0647	Training
0648	Training
0649	Other IV Therapy Services
0650	Hospice Services
0660	Respite Care
0661	Respite Care - Hourly
0662	Respite - Hourly
0770	Preventive Care Services
0771	Preventive Care Services/Vaccine Admin
0780	Telemedicine
0822	Hemodialysis / Home Supplies
0823	Hemodialysis / Home Equipment
0824	Hemodialysis / Home Equipment
0825	Hemodialysis / Support Services
0832	Peritoneal Dialysis / Home Supplies
0833	Peritoneal Dialysis / Home Equipment
0834	Peritoneal Dialysis / Maintenance 100%
0835	Peritoneal Dialysis / Support Services
0842	CAPD / Home Supplies
0843	CAPD / Home Supplies
0844	CAPD / Maintenance 100%
0845	CAPD / Support Services

Non-Covered Revenue Codes	
0852	CCPD / Home Supplies
0853	CCPD / Home Equipment
0854	CCPD / Maintenance 100%
0855	CCPD / Support Services
0882	Home Dialysis Aide Visit
0941	Recreational Therapy
0942	Education / Training
0943	Cardiac Rehabilitation
0946	Complex Medical Equipment
0947	Complex Medical Equipment/Ancillary
0948	Pulmonary Rehabilitation
0949	Additional Other Therapeutic Services
0989	Professional Fees / Private Duty Nurse
0990	Patient Convenience Items
0991	Cafeteria / Guest Tray
0992	Private Linen Service
0993	Telephone / Telecom
0994	Television / Radio
0995	Nonpatient Room Rentals
0996	Late Discharge Charge
0997	Admission Kits
0998	Beauty Shop / Barber
0999	Other Patient Convenience Items
2100	General Classification
2101	Acupuncture
2102	Acupressure
2103	Massage
2104	Reflexology
2105	Biofeedback
2106	Hypnosis
2109	Other Alternative Therapy Services
3101	Adult Day Care, Medical and Social - Hourly
3102	Adult Day Care, Social - Hourly
3103	Adult Day Care, Medical And Social - Daily
3104	Adult Day Care, Social - Daily
3105	Adult Foster Care - Daily
3109	Other Adult Care

Series-Billable Revenue Codes	
Revenue Code	**Revenue Description**
0260	IV Therapy
0261	IV Therapy/Infusion Pump
0269	Other IV Therapy
0280	Oncology
0289	Other Oncology
0330	Radiology - Therapeutic
0331	Chemotherapy - Injected
0332	Chemotherapy - Oral
0333	Radiation Therapy
0335	Chemotherapy - IV
0339	Radiology - Therapeutic / Other
0340	Nuclear Medicine Or (NUC Med)
0341	Nuclear Medicine / Diagnostic
0342	Nuclear Medicine / Therapeutic
0343	Diagnostic Pharmaceuticals
0344	Therapeutic Radiopharmaceuticals
0349	Nuclear Medicine / Other
0410	Respiratory Services
0412	Inhalation Services
0413	Hyperbaric Oxygen Therapy
0419	Other Respiratory Services
0420	Physical Therapy
0421	Physical Therapy / Visit Charge
0422	Physical Therapy / Hourly Charge
0423	Physical Therapy / Group Rate
0424	Physical Therapy / Evaluation or Re-Eval
0429	Other Physical Therapy
0820	Hemodialysis - Outpatient or Home
0821	Hemodialysis / Composite or Other Rate
0829	Hemodialysis / Other Outpatient Hemodialysis
0830	Peritoneal Dialysis / Outpatient or Home
0831	Peritoneal Dialysis / Composite or Other Rate
0839	Other Outpatient Peritoneal Dialysis
0840	CAPD / Outpatient or Home
0841	CAPD / Composite or Other Rate
0849	Other Outpatient CAPD
0850	CCPD / Outpatient or Home
0851	CCPD / Composite or Other Rate

Series-Billable Revenue Codes	
0859	Other Outpatient CCPD
0900	Psychiatric / Psychological Treatments
0901	Electroshock Treatment
0902	Milieu Therapy
0903	Play Therapy
0904	Activity Therapy
0911	Rehabilitation
0912	Partial Hospitalization-Less Intensive
0913	Partial Hospitalization-Intensive
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0917	Bio Feedback
0918	Testing
0919	Other Psychiatric/Psychological Services

Age-Restricted Revenue Codes

Revenue Code	Covered Age Range	Revenue Description
0112	10 and up	OB/PVT
0113	0 – 16	Pediatric/PVT
0122	10 and up	OB/2Bed
0123	0 – 16	Pediatric /2- Bed
0132	10 and up	Medical-Surgical-GYN/3&4 Bed
0133	0 – 16	Pediatric/3 & 4- Bed
0142	10 and up	OB/DLX
0143	0 – 16	Pediatric/DLX
0152	10 and up	OB/Ward
0153	0 – 16	Pediatric/Ward
0170	0 – 2	Nursery
0171	0 – 2	Nursery/Level I
0172	0 – 2	Nursery/Level II
0173	0 – 2	Nursery/Level III
0174	0 – 2	Nursery Level IV
0179	0 – 2	Nursery/Other
0203	0 – 16	Intensive Care/Pediatric
0515	0 – 16	Pediatric Clinic
0720	10 and up	Delivery Room/Labor
0721	10 and up	Labor
0722	10 and up	Delivery Room
0729	10 and up	Other Delivery Room/Labor
0925	10 and up	Pregnancy Test

Sex-Restricted Revenue Codes		
Revenue Code	**Covered Sex Code**	**Revenue Description**
0112	F	OB-PVT
0122	F	OB/2-Bed
0132	F	Medical-Surgical-GYN/3 & 4-Bed
0142	F	OB/DLX
0152	F	OB/Ward
0403	F	Screening Mammography
0514	F	OB/GYN Clinic
0720	F	Delivery Room/Labor
0721	F	Labor
0722	F	Delivery Room
0729	F	Other Delivery Room/Labor
0923	F	PAP Smear
0925	F	Pregnancy Test

Revenue Codes Not Billable for Adults 19 and Over on State Family and Children Assistance Cases

Revenue Code	Revenue Description
0114	Psychiatric/PVT
0118	Rehabilitation/PVT
0124	Psychiatric/2-Bed
0128	Rehabilitation/2-Bed
0134	Psychiatric/3 & 4-Bed
0138	Rehabilitation/Semi-Private 3 & 4-Bed
0144	Psychiatric/DLX
0148	Rehabilitation/PVT
0154	Psychiatric/Ward
0158	Rehabilitation Room and Board/Ward
0204	Intensive Care/Psychiatric
0513	Psychiatric Clinic
0900	Psychiatric/Psychological Treatments
0901	Electroshock Treatment
0902	Milieu Therapy
0903	Play Therapy
0904	Activity Therapy
0906	Intensive Outpatient Services - Chemical
0911	Rehabilitation
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0917	Bio Feedback
0918	Psychiatric Testing
0919	Other Psychiatric/Psychological Testing
0944	Drug Rehabilitation
0945	Alcohol Rehabilitation
0961	Professional Fees
0977	Professional Fees/Physical Therapy

Appendix H-4

DRG Calculation Worksheets, Per Diem Cost Outlier Worksheet, and Table B - DRG Reimbursement Factors

The DRG Calculation Worksheets, Per Diem Cost Outlier Worksheet, and Table B - DRG Reimbursement Factors are available on the department's Web site.