Facility Billing Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on UB-04 forms and, when specified, to those billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design, and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities, including but not limited to, non-network authorized and percent of charge contract facilities.

Policy

Overview

The uniform bill known as the UB-04, also called the CMS-1450, is used by Medicare and many major third-party payers for billing facility services.

The data elements and design of the billing formats are determined by the National Uniform Billing Committee (NUBC) at the request of CMS, the state uniform billing committees (SUBC) and provider and payer associations. Most of the UB-04 Form Locators (FLs) are required data elements for Medicare billing. Unassigned codes and spaces on the claim form are available to meet the future reporting needs of CMS and state and local regulatory agencies and payer-specific requirements for hospital billing. The form and EDI format are flexible to accommodate most third-party payers and hospitals and to promote uniform use of the claim. The FL requirements, revenue codes and subcategory codes are revised on an ongoing basis by the NUBC.

Reimbursement Guidelines

This policy addresses Form Locators (FLs) on the UB-04 and the required information for each field. If the information submitted is missing, incomplete, or invalid, the claim will be denied. Fields included in this policy include, but are not limited to:

- Bill Type

- Discharge Status
- Principal diagnosis
- Source of Admission
- Condition code
- Type of Admission
- Patient age
- Patient gender

Other information that is required and will cause claim denials if incorrect includes, but is not limited to:

- Age to procedure &/or diagnosis conflict
- Gender to procedure &/or diagnosis conflict
- Procedure &/or diagnosis code requires additional digit(s)
- Use of E code as a primary diagnosis
- Services provided after the discharge date range
- Mismatched International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) codes

State Exceptions	
Florida	Inpatient admissions effective 02/01/2021 and after, per Florida State requirements, Providers will follow the directive below when submitting Interim Claims for Inpatient members when the length of stay exceeds 100 days: 1. Providers will bill the first 100 days using: • Type of Bill (TOB) 112 (first interim claim) • Discharge Status should reflect member is still Inpatient • Admission date to current date 2. Providers will bill for additional days after the initial billing using: • TOB 113 (continuing claim) • Discharge status that reflects member is still Inpatient • Admission date to current date • Claims should include billed amounts from previously billed claims through current billing dates • Previously billed claims will be voided and replaced with subsequent claims 3. Providers will bill the Final claim using • TOB 114 (discharge TOB) • Discharge status should reflect member has been discharged • Admission date to discharge date • Claims should include billed amounts from previously billed claims through discharge billing date • Previously billed claims will be voided and replaced with Final claim
Maryland	Inpatient Claims admission date must be between the "From" and "Through" dates but can be no more than 3 calendar days from the "From" date, with the exception of Type of Bill Frequency Codes.
Texas	• Per Texas Guidelines: • The admission date must be prior to the statement begin date on an Institutional encounter claim. • Claims billed with Frequency Code of 2 (Interim-First Claim), 3 (Interim-Continuing Claims), or 4 (Interim-Last Claim) must be submitted with an Institutional Type of Bill: 11X, 12X, 18X, 21X, 22X, 28X, 41X, 86X.

Questions and Answers	
1	**Q:** What is the source of these Facility Edits?

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	A: Some of these edits are sourced to the CMS Medical Code Edits (MCE). Please see the CMS website (www.cms.gov) for further information on the content of these edits. Others are sourced to NUBC.
2	**Q**: What types of scenarios are addressed in these Facility Edits? **A**: These edits are intended to ensure that facilities submit correctly coded, clean claims. They address things like diagnoses having the correct number of digits, procedures and diagnoses are appropriate for the age and/or gender of the member, the discharge status on the claim is valid, and both the Admission and Discharge dates are valid for the claim.

Resources

National Uniform Billing Committee (NUBC) CMS

Medical Code Edits (MCE) OptumInsight, Inc. *UB Editor*

American Medical Association*, Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History

3/27/2024	Policy Verbiage updated State Maryland & Texas entries updated
3/5/2024	Policy Version Change Logo Updated Reimbursement Guidelines updated History Section: Deleted entries prior to 03/10/2022
9/1/2012	Policy Posted by UnitedHealthcare Community & State

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