Uniform Billing Editor

The Ultimate Guide to Accurate Facility Claim Submission

OPTUM360°®
Contents

Chapter I. How to Use the Uniform Billing Editor ............................................. I-1
Introduction ............................................................................................................ I-1
Contents ...................................................................................................................... I-4
Organization ............................................................................................................ I-6
Step-by-Step Instructions ....................................................................................... I-7
Alternative Resources .......................................................................................... I-14

Chapter II. Provider, Patient and Admission Information (FLs 1–17) .......... II-1
FL 1 Billing Provider Name, Address and Telephone Number ....................... II-3
FL Coding Structure ............................................................................................... II-6
FL 2 Billing Provider’s Designated Pay-to Address ........................................ II-7
FL 3a Patient Control Number ............................................................................ II-9
FL 3b Medical/Health Record Number ............................................................. II-10
FL 4 Type of Bill ................................................................................................... II-11
First Digit—Type of Facility ................................................................................ II-14
Second Digit—Type of Facility ............................................................................ II-14
Third Digit—Bill Classification ........................................................................... II-15
Fourth Digit—Frequency of the Bill—Other Patients ...................................... II-154
Fourth Digit—Frequency of the Bill—For Hospice Only .................................. II-162
Fourth Digit—Frequency of the Bill—Other ..................................................... II-163
FL 5 Federal Tax Number .................................................................................... II-166
FL 6 Statement Covers Period ............................................................................. II-167
FL 7 Reserved ....................................................................................................... II-171
FL 8 Patient Name/Identifier ............................................................................. II-172
FL 9 Patient Address ............................................................................................ II-174
FL 10 Patient Birth Date ..................................................................................... II-176
FL 11 Patient Sex .................................................................................................. II-178
FL 12 Admission/Start of Care Date ................................................................. II-179
FL 13 Admission Hour ........................................................................................ II-181
FL Coding Structure ............................................................................................. II-181
FL 14 Priority (Type) of Admission/Visit ........................................................... II-182
FL Coding Structure ............................................................................................. II-183
FL 15 Point of Origin for Admission or Visit ..................................................... II-184
FL Coding Structure (for Emergency, Elective or Other Type of Admission) ...II-185
FL Coding Structure: Newborn .......................................................................... II-187
FL 16 Discharge Hour .......................................................................................... II-188
FL 17 Patient Discharge Status .......................................................................... II-189
FL Coding Structure ............................................................................................. II-191

Chapter III. Condition, Occurrence and Value Codes (FLs 18–41) ........ III-1
FLs 18–28 Condition Codes ................................................................................ III-3
FL Coding Structure ............................................................................................. III-4
FL 29 Accident State ........................................................................................... III-36
FL 30 Reserved ..................................................................................................... III-36
FLs 31–34 Occurrence Codes and Dates ............................................................. III-37
FL Coding Structure ............................................................................................. III-39
FLs 35–36 Occurrence Span Codes and Dates .................................................... III-58
FL Coding Structure ............................................................................................. III-59
FL 37 Reserved ..................................................................................................... III-65
FL 38 Responsible Party Name and Address .................................................... III-66
FL Coding Structure

01 Accident/Medical Coverage

This code and corresponding date indicate an accident-related injury for which there is medical payment coverage. Provide the date of the accident or injury.

- This code identifies an injury or illness that resulted from an accident. MSP provisions apply.
- If this occurrence code is used, Medicare is not the primary payer for this claim. There can be no Medicare insurance entries on line A of FL 50 or FLs 58–62 to indicate that Medicare is primary.
- This occurrence code is valid when used with any TOB codes (FL 4) applicable to Medicare providers.
- The use of an accident code also requires that the accident hour be reported with value code 45 Accident hour, in FLs 39–41.
- The date provided with this code must not be after the through date in the statement covers period (FL 6).
- When billing clinic services (TOB code 071X in FL 4), there must be a value code 14 No-fault, including auto/other, and amount reported in FLs 39–41.
- Certain trauma diagnosis codes may identify claims for patients covered under automobile insurance, no-fault, workers’ compensation, or other liability insurance for which Medicare should be the secondary payer. If the principal diagnosis code reported in FL 67 indicates trauma according to MSP development criteria, an occurrence code (e.g., 01–05) and value code 45 Accident hour (FLs 39–41), must be entered on the bill.
- This code also must be accompanied by an appropriate entry in the Value Code and Amount fields (FLs 39–41) indicating the primary payment amount when another payer is involved.
- Conditional Medicare benefits may be paid while an auto accident claim is pending payment. There must be documentation that the insurer will not pay promptly or within 120 days after receipt of the claim. The date of service for specific items and service must be treated as the claim date when determining the prompt pay period. For inpatient services, the date of discharge must be treated as the date of service when determining the prompt pay period. (Medicare Secondary Payer Manual, Pub. 100-05, chap. 1, secs. 10.7–10.7.2, chap. 3, secs. 30.2.1.1–30.2.2, chap. 5, secs. 40.6.1–40.6.2 [trans.107, October 24, 2014])

The following billing guidelines apply:
- Provide the appropriate occurrence codes and dates. For example, use occurrence code 24 Date insurance denied, to bill Medicare for a conditional payment when the auto accident insurer denies the claim for invalid reasons or there has been a significant delay (more than 120 days) in receiving primary payment.
- Show value code 47 Any liability insurance, with a zero dollar amount in FLs 39–41.
- On line FL 50 A Payer, indicate the primary payer responsible for ultimately paying the claim.
- In FLs 58 A–60 A, identify all information pertaining to the primary insured (i.e., the insured’s name [FL 58 A], patient relationship [FL 59 A], certificate number [FL 60 A]).
- Use the Remarks field (FL 80) to explain why the conditional payment is being requested (i.e., reason why insurer denied, the attorney’s name and address).
Ancillary Services Revenue Codes (040X–049X)

040X # Tests Other Imaging Services
This code indicates charges for specialty imaging services of body structures.

- The APC payment for radiology includes pharmacy (except those billed under RC 0343, 0344, or 0636), anesthesia and supplies used in connection with the radiology service. Providers may bill these incident to services as part of the amount for the other imaging procedure, or bill them separately using one of the incident to radiology revenue codes for pharmacy (RC 0255), anesthesia (RC 0371) or supplies (RC 0621).

  - If billed separately, the charge must appear on the same claim as the other imaging procedure. Should the charges need to be added to a claim that has already been paid, they must be billed on an adjustment claim (TOB code 0XX7).
  - HCPCS codes are not required when billing packaged drugs, biologicals, or radiopharmaceuticals. However, CMS strongly encourages hospitals to include all appropriate HCPCS codes (FL 44) on a claim.

- Provide the number of radiology tests or services for the revenue code category 040X in the Units field (FL 46).

- Other imaging services are classified as diagnostic services under the preadmission provisions outlined in Medicare Claims Processing Manual, Pub. 100-04, chap. 3, sec. 40.3. When performed by the admitting hospital or by an entity wholly owned or operated by the hospital (or by another entity under arrangement with the hospital) within three days immediately prior to an admission to a PPS hospital the services are included in the MS-DRG payment unless there is no Part A coverage. These services must be reported on the inpatient bill.

  - An entity is considered wholly owned or operated by a hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility to be considered the sole operator, but it must have exclusive responsibility for implementing facility policies, such as conducting or overseeing a facility’s routine operations.

- The dates of service on an outpatient claim for diagnostic services must not overlap the through date in the statement covers period (FL 6) or a last date of service (occurrence span code 72 First/last visit [FL 36]) that falls on the day of admission or within three days of an admission to a PPS hospital.

- According to national billing guidelines, TRICARE requires the use of a detail code, rather than the general RC 0400.

- HCPCS codes are required in FL 44 HCPCS/Rates, for billing other imaging services under RC 040X with TOB code (FL 4) 013X or 083X. (Medicare Claims Processing Manual, Pub. 100-04, chap. 3, sec. 2011)

- HCPCS codes 70010–79999 are valid when reported with this revenue code for all Medicare outpatient claims.

- Hospitals may use CPT modifiers 50, 52, 59, 76, and 77, and HCPCS Level II modifiers E1–E4, FA, F1–F9, LT, RT, and TA–T9 as appropriate for radiology procedures. Modifier S2 (reduced services) may be used with a radiology procedure if there is no other CPT code available to report the reduced service. (See also appendix 5 for detailed coding tips regarding usage of this modifier.) (Medicare Claims Processing Manual, Pub. 100-04, chap. 4, secs. 20.6, 20.6.4)

  - For example, if the planned procedure is a two-view chest x-ray and only one view of the chest is performed, do not report CPT code 71020-52 (for x-ray chest, two views-reduced service). Instead, report CPT code 71010 (x-ray chest, single view). If a barium swallow is not completed because the patient cannot handle the barium, report CPT code 74270-52.
### Numeric List of CPT/HCPCS Codes

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<th>CPT/HCPCS</th>
<th>Revenue Code</th>
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* This code is not covered under Medicare OPPS
  a Not to be used for OPPS billing
  b Inpatient only procedure under OPPS
  c ESRD only
  d HHA only

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### New or Changed Information

**Appendixes, Glossary, and Index**

**Chapter VII.**

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**CPT/HCPCS** | Revenue Code
---|---
45388-45393 | 0360, 0361, 0450, 0490a, 0510, 0516, 0517, 0519, 0750
45395b-45397b | 0360
45398-45399 | 0360, 0361, 0450, 0490a, 0510, 0514, 0515, 0516, 0517, 0519, 0750
45400b-45402b | 0360
45499 | 0360, 0361, 0450, 0490a, 0510, 0514, 0516, 0517, 0519, 0750, 0761
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45540b | 0360
45541 | 0360, 0361, 0450, 0490a, 0510, 0519, 0750
45550b | 0360
45560-45590 | 0360, 0361, 0450, 0490a, 0510, 0514, 0515, 0516, 0517, 0519, 0750
45562b-455825b | 0360
45900-45915 | 0360, 0361, 0450, 0490a, 0510, 0514, 0515, 0516, 0517, 0519, 0750
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46230-46288 | 0360, 0361, 0450, 0490a, 0510, 0514, 0515, 0516, 0517, 0519
46320-46500 | 0360, 0361, 0450, 0490a, 0510, 0514, 0515, 0516, 0517, 0519, 0750
46600-46700 | 0360, 0361, 0450, 0490a, 0510, 0514, 0515, 0516, 0517, 0519, 0750

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  c ESRD only
  d HHA only

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