CLAIMS FILING

Claims for Adult Day Health Care Services must be filed by electronic claims submission 837I or on the UB 04 claim form.

This appendix includes the following:

- Instructions for completing the UB 04
- Samples of UB 04 claim form

Instructions for Completing the UB04 for Adult Day Health Care

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	Required. Enter the name and address of the facility.	
2	Pay to Name/Address/ID	Situational. Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	Optional. Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record #	Optional. Enter patient's medical record number (up to 24 characters)	
4	Type of Bill	Required. Enter the appropriate 3-digit code as follows: *1st Digit - Type of Facility* 8 = Special Facility (LOC=Adult Day Health Care) *2nd Digit - Classification* 9 = Other (Adult Day Health Care - ADHC) *3rd Digit – Frequency Definition* 1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment. 3 = Interim - Continuing Claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 = Interim - Final Claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death. 7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.	

Locator #	Description	Instructions	Alerts
5	Federal Tax No.	Optional.	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	Required. Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	Leave blank.	
8	Patient's Name	Required. Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	Required. Enter patient's permanent address appropriately in Form Locator 9a-e. 9a = Street address 9b = City 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birth Date	Required. Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	Required. Enter sex of the patient as: M = Male F = Female U = Unknown	
12	Admission Date	Required. Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	Leave blank.	
14	Type Admission	Leave blank.	
15	Source of Admission	Leave blank.	
16	Discharge Hour	Leave blank.	

Locator #	Description	Instructions	Alerts
17	Patient Status	Required. Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6). Valid Codes 01 = Discharged to home or self-care (routine discharge) 02 = Discharged/transferred to another short-term general hospital for inpatient care 03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF) 04 = Discharged/transferred to another type of institution for inpatient care 06 = Discharged/transferred to home under care of home health services organization 07 = Left against medical advice or discontinued care 09 = Admitted as inpatient to a hospital 20 = Expired/Discharged Due to Death 30 = Still a patient 61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed 62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital 63 = Discharged/transferred to a long term care hospital	
18-28	Condition Codes	Leave blank.	
29	Accident State	Leave blank.	
30	Unlabeled Field	Leave blank.	
31-34	Occurrence Codes/Dates	Leave blank.	
35-36	Occurrence Spans (Code and Dates)	Leave blank.	
37	Unlabeled	Leave blank.	
38	Responsible Party Name and Address	Optional.	

Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	Required. Enter the appropriate Value Code (listed below). *80 = Covered Total Units *Enter the appropriate Value Code in the code portion of the field and the total number of quarter hour units billed (total hours of attendance x 4 quarter units = Total Units), not the total number of days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.	Enter total number of units billed on the claim, not the number of days
42	Revenue Code	Required. Enter the applicable revenue code(s) which identifies the service provided. Revenue Code & Description *(Corresponding Level of Care)* 932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day *(27 = Adult Day Health Care)*	
43	Revenue Description	Required. Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPCS/Rates HIPPS Code	Leave blank.	
45	Service Date	Required. Enter the day of service for each day services are provided (e.g., 01-01, 02-02, 03-03, etc.) for each revenue code indicated. Enter a service line for each service day. Required. Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.	Creation date must be later than the through date in Form Locator 6.
46	Units of Service	Required. Enter the total number of units for each day of service. 1 unit = 15 minutes of service Note: ADHC cannot exceed 23 days per month. Enter the number of days of service provided as individual detail lines.	Reminder: 1 Unit is equal to 15 minutes of service
47	Total Charges	Leave Blank.	
48	Non-Covered Charges	Leave Blank.	

Locator #	Description	Instructions	Alerts
49	Unlabeled Field (National)	Leave Blank.	
50-A,B,C	Payer Name	Situational. Enter insurance plans other than Medicaid on Lines "A", "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is required. The Medically Needy Spend down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.	
51-A,B,C	Health Plan ID	Situational. Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C. If other insurance companies are listed, then entry of their Health Plan ID numbers is required.	
52-A,B,C	Release of Information	Optional.	
53-A,B,C	Assignment of Benefits Cert. Ind.	Optional.	
54-A,B,C	Prior Payments	Situational. Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C. If private insurance was available, but no private insurance payment was made, then enter '0' or '0.00' in this field.	
55-A,B,C	Estimated Amt. Due	Optional.	
56	NPI	Required. Enter the provider's National Provider Identifier (NPI)	The 10-digit NPI must be entered here.
57	Other Provider ID	Required. Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	The 7-digit Medicaid ID number must be entered here.
58-A,B,C	Insured's Name	Required. Enter the recipient's name as it appears on the Medicaid ID card in 58A. Situational: If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.	

Locator #	Description	Instructions	Alerts
59-A,B,C	Patient's Relationship to Insured	Situational. If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows: 01 = Patient is insured 02 = Spouse 03 = Natural child/Insured has financial responsibility 04 = Natural child/ Insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored dependent 17 = Minor dependent of minor dependent 18 = Parent 19 = Grandparent	
60-A,B,C	Insured's Unique ID	Required. Enter the recipient's 13-digit Medicaid Identification Number in 60A. Situational. If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	Situational. If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.	
63-A,B,C	Treatment Auth. Code	Required. Enter the 9-digit prior authorization number in 63A	

Locator #	Description	Instructions	Alerts
64-A,B,C	Document Control Number	Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate in 64A. Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B. Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	To adjust or void more than one claim line, a separate UB-04 form is required for each claim line since each line has a different internal control number.
65-A,B,C	Employer Name	Situational. If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	Leave blank.	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	Required. Enter the ICD-9-CM code for the principal diagnosis. Situational. Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim. Note: Use the most specific and accurate ICD-9-CM Diagnosis Code. A 3-digit Diagnosis Code is to be used only if it is not further subdivided. Where 4-digit subcategories and/or 5-digit sub-classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with "E" or "M" are not acceptable for any Diagnosis Code.	ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).
68	Unlabeled	Leave blank.	

Locator #	Description	Instructions	Alerts
69	Admitting Diagnosis	Optional. Enter the admitting Diagnosis Code.	Refer to field locator 67.
70	Patient Reason for Visit	Leave blank.	
71	PPS Code	Leave blank.	
72- A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74 74 a – e	Principal Procedure Code / Date Other Procedure Code / Date	Leave blank.	
75	Unlabeled	Leave blank.	
76	Attending	Leave blank.	This field must be completed.
77	Operating	Leave blank.	
78	Other	Leave blank.	
79	Other	Leave blank.	
80	Remarks	Situational. Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

Signature is not required on the UB-04.

SAMPLE ADHC CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

SAMPLE

EXAMPLE OF ICD 9

1 ADULT DAY CARE
9876 LOLLIPOP LANE
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 11111111111
4 TYPE OF BILL 893
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 091015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET b ANYWHERE c LA d 71111

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
010143	M	120513					30

18–28 CONDITION CODES; 29 ACDT STATE; 30
31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37
38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	104 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	932	Adult Day Health Care		01-01	24			
2	932	Adult Day Health Care		03-03	28			
3	932	Adult Day Health Care		08-08	24			
4	932	Adult Day Health Care		10-10	28			
23		PAGE 1 OF 1	CREATION DATE	093015	TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
A MEDICAID				TPL		57 OTHER PRV ID 1234567
B				PAYMENT IF		
C				APPLICABLE		

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN		1234567890123	TPL CARRIER	
B			CODE IF	
C			APPLICABLE	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 987654321		

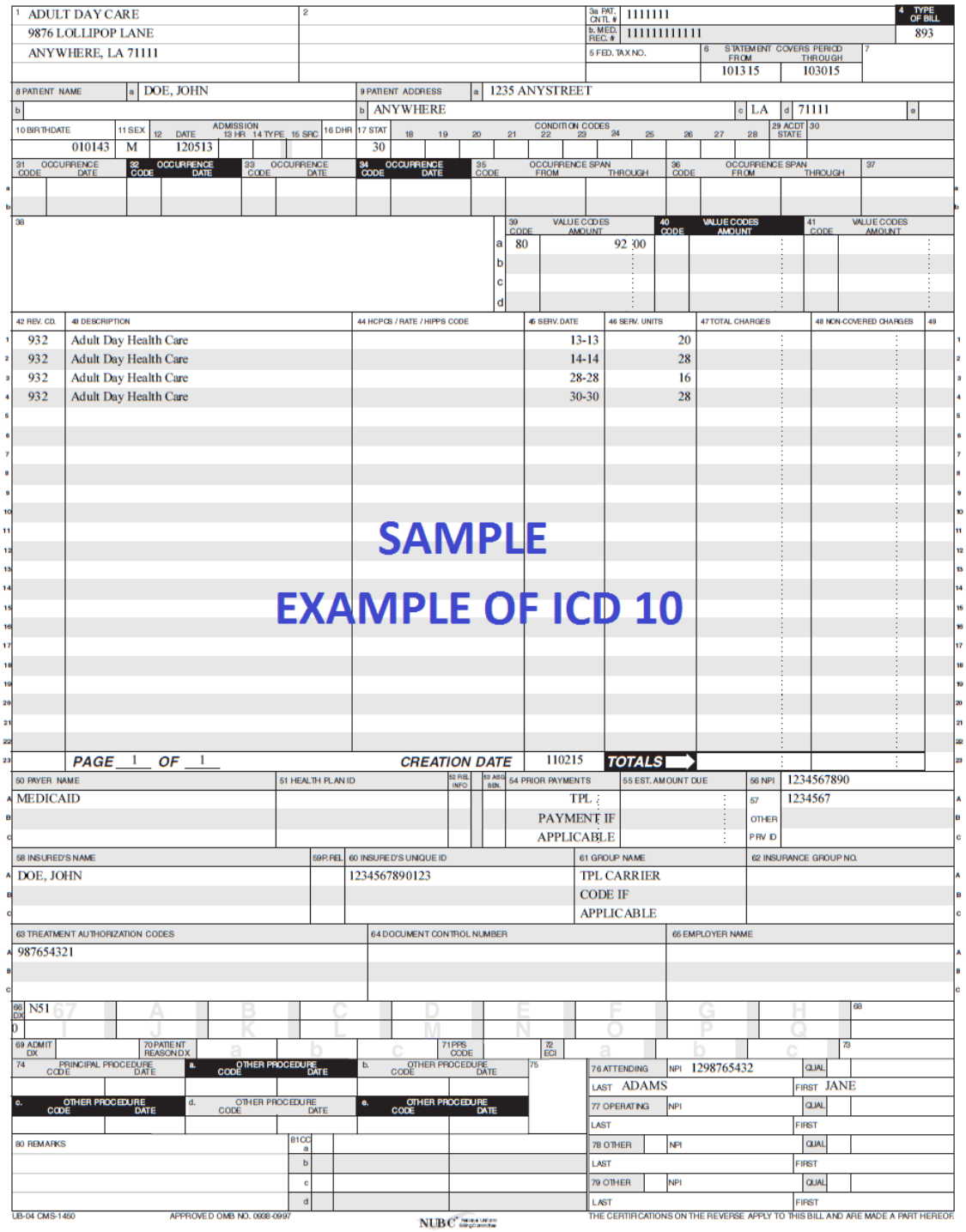
66 DX 67 6014

69 ADMIT DX; 70 PATIENT REASON DX; 71 PPS CODE; 72 ECI; 73
74 PRINCIPAL PROCEDURE CODE DATE; a.–e. OTHER PROCEDURE CODE DATE; 75

76 ATTENDING NPI 1298765432 QUAL
LAST ADAMS FIRST JANE
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS; 81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE ADHC CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)



1 ADULT DAY CARE
9876 LOLLIPOP LANE
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 893
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 101315 THROUGH 103015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE 010143 | 11 SEX M | 12 ADMISSION DATE 120513 | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT 30 | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	92 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	932	Adult Day Health Care		13-13	20			
2	932	Adult Day Health Care		14-14	28			
3	932	Adult Day Health Care		28-28	16			
4	932	Adult Day Health Care		30-30	28			
5–22								
23	PAGE 1 OF 1		CREATION DATE	110215	TOTALS			

SAMPLE

EXAMPLE OF ICD 10

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
A	MEDICAID				TPL PAYMENT IF APPLICABLE		57 OTHER PRV ID	1234567
B								
C								

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN		1234567890123	TPL CARRIER CODE IF APPLICABLE	
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	987654321		
B			
C			

66 DX 0 | 67 N51 | A | B | C | D | E | F | G | H | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

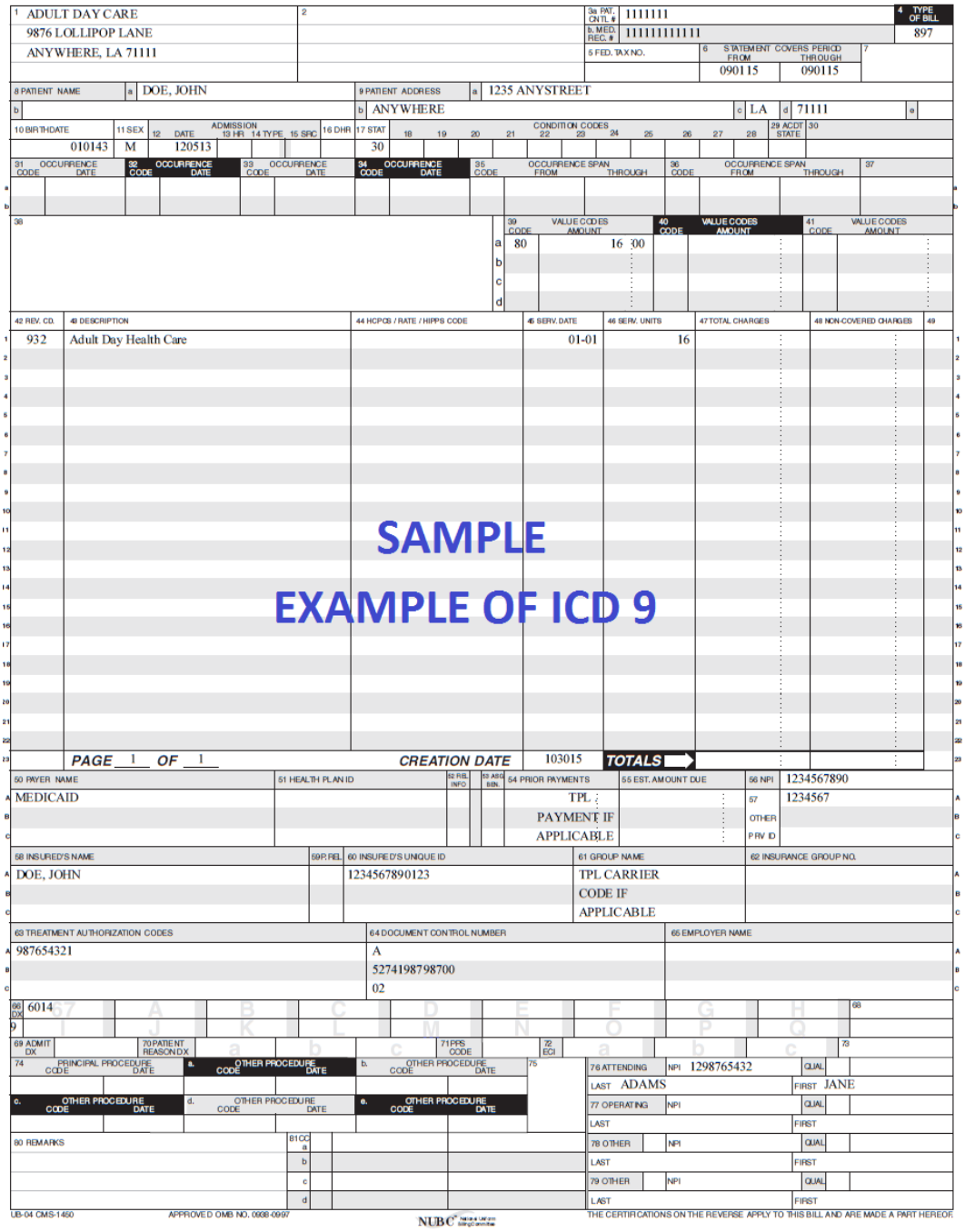
74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

80 REMARKS | 81 CC a b c d

76 ATTENDING NPI 1298765432 QUAL | LAST ADAMS | FIRST JANE
77 OPERATING NPI QUAL | LAST | FIRST
78 OTHER NPI QUAL | LAST | FIRST
79 OTHER NPI QUAL | LAST | FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE ADHC CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)



1 ADULT DAY CARE
9876 LOLLIPOP LANE
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 897
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 090115

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111

10 BIRTHDATE 010143
11 SEX M
12 ADMISSION DATE 120513
17 STAT 30

39 VALUE CODES a 80 16 00

42 REV. CD. 932
49 DESCRIPTION Adult Day Health Care
45 SERV. DATE 01-01
46 SERV. UNITS 16

SAMPLE
EXAMPLE OF ICD 9

PAGE 1 OF 1
CREATION DATE 103015
TOTALS

50 PAYER NAME A MEDICAID
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME A DOE, JOHN
60 INSURED'S UNIQUE ID 1234567890123
61 GROUP NAME TPL CARRIER CODE IF APPLICABLE

63 TREATMENT AUTHORIZATION CODES A 987654321
64 DOCUMENT CONTROL NUMBER A 5274198798700 02

66 DX 9 6014

76 ATTENDING NPI 1298765432 LAST ADAMS FIRST JANE

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE ADHC CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)