CLAIMS FILING

The claims filing appendix includes the following information:

- Instructions for completing the UB 04 claim form
- Samples of a UB 04 claim form for ICF/ID routine billing

Instructions for Completing the UB04 for ICF/ID Facility

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* 6 = Intermediate Care(LOC = ICF/MR) *2nd Digit - Classification* 5 = Intermediate Care Level I 6 = Intermediate Care Level II *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.	
5	Federal Tax No.	Optional.	

Locator #	Description	Instructions	Alerts
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 six 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 days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims) *Enter the appropriate Value Code in the code portion of the field and the 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.	Covered Days is reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04. Value Codes 81, 82, and 83 are not used for straight Medicaid billing.
42	Revenue Code	Required. – Enter the revenue code(s) which identifies the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions to bill LA Medicaid: Revenue Code & Description *(Corresponding Level of Care)* 193 = Pervasive Level of Care (ICAP Score 1-19) 192 = Extensive Level of Care (ICAP Score 20-39) 191 = Limited Level of Care (ICAP Score 40-69) 190 = Intermittent Level of Care (ICAP Score 70-99) NOTE: Providers will be paid at the Intermittent level of care should a recipient not have an ICAP level on file. All recipients must have an ICAP Assessment on file. Revenue Code & Description Leave of Absence 183 = Leave of Absence - Subcategory Therapeutic (for Home Leave) 185 = Leave of Absence - Subcategory Nursing Home (for Hospitalization)	
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.	

Locator #	Description	Instructions	Alerts
45	Service Date	Required. – Enter a beginning and ending day of service (e.g., 01-31) for each revenue code indicated. The service day range should be the first day through the last day of the month on which the service was provided. Example 1: If SNF TDC care (Revenue Code 194) is provided for the entire month of March, the Service Date should be entered 01-31. Example 2: If the recipient is on hospital leave (Revenue Code 185) from March 06 -12, the Service Date should be entered 07-12, -- If the recipient was discharged while on leave from the facility, the leave days should be cut back by one day (e.g. 07-11). Note: The claim must reflect the total number of days billed at a particular Level of Care (LOC) corresponding to the Revenue Code for that LOC. If the LOC changes during the month, another claim line must be entered with the appropriate Revenue Code for that LOC and the correct number of days indicated for that LOC for the month of service. 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.	
46	Units of Service	Required. – Enter in DAYS the number of units of service for each Level of Care type on the line adjacent to the Level of Care revenue code, description, and service date. Example 1: Service Date 01-31 should indicate 31 units or days for Revenue Code 194. Note: Do not enter the actual number of units when billing for home or hospital leave days, only indicate the "from" and "to" days in Form Locator 45. Example 2: (Revenue Code 185), Service date 07-12, service units should be left blank.	
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. If the patient is a Medically Needy Spend-Down recipient or has made payment for non-covered services, indicate the recipient name (as entered in Form Locator 8) as payer and the amount paid. 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	Optional. – Enter the provider's National Provider Identifier (NPI)	The 10-digit NPI must be entered here.
57-A,B,C	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.

Locator #	Description	Instructions	Alerts
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.	
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 as it appears on the Medicaid ID card 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.	

Locator #	Description	Instructions	Alerts
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.	ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field. DO NOT enter dashes, hyphens, or the word TPL in the field. NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE
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	Leave blank.	
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	

Locator #	Description	Instructions	Alerts
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	Required. - Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM	
67 67 A-Q	Principal Diagnosis Codes Other Diagnosis code	Required. – Enter the ICD code for the principal diagnosis. Situational. – Enter the ICD code or codes for all other applicable diagnoses for this claim. Use the most specific and accurate code. A code is invalid if it has not been coded to the full number of digits required for that code. Note: ICD 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.	
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.	

Locator #	Description	Instructions	Alerts
74 74 a – e	Principal Procedure Code / Date Other Procedure Code / Date	Leave blank.	
75	Unlabeled	Leave blank.	
76	Attending	Required. Enter the name and NPI number of the physician ordering the plan of care.	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 ICF/ID FACILITY CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

1 BLOMMING ICF-DD FACILITY
1800 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 653
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 090115 THROUGH 093015

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

10 BIRTHDATE MMDDYY
11 SEX M
12 ADMISSION DATE 080115
17 STAT 30

39 VALUE CODES CODE	AMOUNT
a 80	30 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
193	CASE MIX		01-30	30		
185	HOSPITAL LEAVE		03-05			
183	HOME LEAVE		12-15			
	PAGE 1 OF 1	CREATION DATE	100315	TOTALS		

SAMPLE

EXAMPLE OF ICD 9

50 PAYER NAME: MEDICAID
51 HEALTH PLAN ID
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE
56 NPI 1234567890
57 OTHER PRV ID 1234567

58 INSURED'S NAME: DOE, JOHN
60 INSURED'S UNIQUE ID: 1234567890123
61 GROUP NAME: TPL CARRIER CODE IF APPLICABLE
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

67 DX 3180

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

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 ICF/ID FACILITY CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)

SAMPLE

EXAMPLE OF ICD 10

Field	Entry
1	BLOMMING ICF-DD FACILITY 1800 CORN ST. ANYWHERE, LA 71111
2	
3a PAT. CNTL #	1111111
b. MED. REC. #	111111111111
4 TYPE OF BILL	654
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	100115 / 102015
7	
8 PATIENT NAME	a DOE, JOHN
9 PATIENT ADDRESS	a 1235 ANYSTREET b ANYWHERE c LA d 71111 e
10 BIRTHDATE	MMDDYY
11 SEX	M
ADMISSION 12 DATE	080115
13 HR / 14 TYPE / 15 SRC / 16 DHR	
17 STAT	01
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	a 80 / 19 00
40 VALUE CODES	
41 VALUE CODES	

	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	193	CASE MIX		01-20	19			
2	185	HOSPITAL LEAVE		03-05				
3	183	HOME LEAVE		12-15				
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE	110515	TOTALS			

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

Field	Entry
66 DX / 67	F71
67 A–Q	
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.–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 ICF/ID FACILITY CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)

1 BLOMMING ICF-DD FACILITY
1800 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL #: 1111111
b. MED. REC. #: 111111111111
4 TYPE OF BILL: 657
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD: FROM 090115 THROUGH 093015

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

10 BIRTHDATE: MMDDYY
11 SEX: M
12 ADMISSION DATE: 080115
17 STAT: 30

39 VALUE CODES: a 80 AMOUNT 30 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
193	CASE MIX		01-30	30		
185	HOSPITAL LEAVE		04-07			
183	HOME LEAVE		10-13			
	PAGE 1 OF 1		CREATION DATE 122815		TOTALS	

SAMPLE

EXAMPLE OF ICD 9

50 PAYER NAME: A MEDICAID
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE
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

64 DOCUMENT CONTROL NUMBER: A 5276198798700 02

66 DX: 9 3180

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

80 REMARKS

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 ICF/ID FACILITY CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)

1 BLOMMING ICF-DD FACILITY
1800 CORN ST.
ANYWHERE, LA 71111

3a PAT. CNTL # 1111111
b. MED. REC. # 111111111111
4 TYPE OF BILL 657
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 102015

8 PATIENT NAME a DOE, JOHN
9 PATIENT ADDRESS a 1235 ANYSTREET
b ANYWHERE c LA d 71111
10 BIRTHDATE MMDDYY
11 SEX M
12 ADMISSION DATE 080115
17 STAT 30

39 VALUE CODES CODE AMOUNT: a 80 19 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
193	CASE MIX		01-20	19		
185	HOSPITAL LEAVE		04-07			
183	HOME LEAVE		10-13			
	PAGE 1 OF 1		CREATION DATE 122815	TOTALS		

SAMPLE

EXAMPLE OF ICD 10

50 PAYER NAME: MEDICAID
54 PRIOR PAYMENTS: TPL PAYMENT IF APPLICABLE
56 NPI 1234567890
57 OTHER PRV ID 1234567

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

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER: A 5309198798700 02
65 EMPLOYER NAME

67 DX: F71

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

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.