

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

III.B. UB-04 Billing Form

The information listed below are the UB-04 fields that must be completed accurately and completely in order to avoid claim suspense or denial. A copy of a UB-04 form follows.

ITEM Description

- 1 **Unlabeled.** Use for hospital information. Enter the name of the hospital. Enter the address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. A telephone number is optional in this field.

- 2 **Unlabeled.** This field must be left blank on all claims submitted to PHC.

- 3A **Patient Control Number.** This is an optional field that will help you to easily identify a recipient on Remittance Advices (RAs). Enter the patient’s financial record number or account number in this field.

- 3B. **Medical Record Number.** Not required by PHC.

- 4 **TYPE OF BILL.** Enter the appropriate three character type of bill code as specified in the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual*. This is a required field when billing PHC.

The following facility type codes are a subset of the NUBC facility type codes commonly used by PHC.

Use one of the following codes as the first two digits of the three-character type of bill code:

<u>Code</u>	<u>Facility Type</u>
11	Hospital – Inpatient (Including Medicare Part A)
12	Hospital – Inpatient (Medicare Part B Only)
13	Hospital – Outpatient
14	Hospital – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment). Use admit type “1” when billing for emergency services.
24	Skilled Nursing – Clinic (For hospital referenced diagnostic services, or home health not under a plan of treatment)
25	Skilled Nursing – Intermediate Care Level II (Level A)
26	Skilled Nursing – Intermediate Care Level II (Level B)
27	Skilled Nursing – Subacute (Use modifier –HB to indicate adult or –HA to indicate child)
33	Home Health – Outpatient

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

- 34 Home Health – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment)
- 44 Religious Non-Medical Health Care Institutions, Hospital Inpatient – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment)
- 54 Religious Non-Medical Health Care Institutions, Post Hospital Extended Care Services – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment)
- 64 Intermediate Care – Other (For hospital referenced diagnostic services or home health not under a plan of treatment)
- 65 Intermediate Care – Intermediate Care Level I
- 71 Clinic – Rural Health
- 72 Clinic – Hospital Based or Independent Renal Dialysis Center
- 73 Clinic – Free Standing
- 74 Clinic – Outpatient Rehabilitation Facility (ORF)
- 75 Clinic – Comprehensive Outpatient Rehabilitation Facility (CORF)
- 76 Clinic – Community Mental Health Center
- 79 Clinic – Other
- 81 Special Facility – Hospice (non-hospital based)
- 83 Special Facility – Ambulatory Surgery Center
- 86 Special Facility – Residential Facility
- 89 Special Facility – Other

ITEM Description

5 Federal Tax Number

6 Statement Covers Period (From-Through)

Inpatient: In six-digit MMDDYY format, enter the dates of service included in this billing. The date of discharge should be entered in the THROUGH Box, even though this date is not reimbursable (unless day of discharge is the date of admission).

Outpatient: Not required.

7 Unlabeled. Not required.

8A Patient Name –ID. Not required

8B Patient Name. Enter the patient’s last name, first name and middle initial (if known).

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 8B. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl". If billing for newborn infants from a multiple birth, each newborn must also be designated by number or letter.

Enter the infant's date of birth and sex in Boxes 10 and 11. Enter the mother's name in Box 58 and enter "03" in Box 59.

When submitting a claim for a patient donating an organ to a Medi-Cal recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Medi-Cal recipient's name in Box 58 and enter "11" in Box 49.

ITEM Description

9A-E Patient Address.

10 Birthdate. Enter the patient's date of birth in an eight-digit MMDDYYYY format. If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns and organ donors, see item 8B above.)

11 Sex. Use the capital letter "M" for male, or "F" for female.

12-13 Admission Date and Hour.

Inpatient. In a six-digit format, enter the date of hospital admission. Enter the admit hour as follows:

- Eliminate the minutes
- Convert the hour of admission/discharge to 24-hour (00-23) format (for example, 3 p.m. =15)

Outpatient. Not required.

14 Admission Type.

Inpatient: Enter the numeric code indicating the necessity for admission to the hospital:

Emergency – 1

Elective – 3

Newborn – 4*

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

*Used only for baby born outside the hospital in conjunction with appropriate revenue code and source of admission.

Outpatient: Enter admit type code “1” in conjunction with facility type “14” when billing for emergency room-related services. Not required for any other use.

15 Admission Source.

Inpatient. If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. When completing this field, code “1” or “3” must be entered in Box 14 to indicate whether the transfer was an emergency or elective.

Source of
Admission

<u>Code</u>	<u>Description</u>
4	Transfer from a hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from another health care facility.

If Admit Type 4 (Newborn) was entered in the admit type box, then a matching Newborn Source of Admission code should be selected.

Newborn Source
Of Admission Codes

For Claims received on or prior to 10/31/16:

4	Extramural Birth
5	Born Inside this Hospital
6	Born Outside this Hospital

For claims received on or after 11/1/16:

5	Born Inside this Hospital
6	Born Outside of this Hospital

Outpatient. Not required.

16 Discharge Hour.

Inpatient. Enter the discharge hour as follows:

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

- Eliminate the minutes
- Convert the hour of discharge to 24-hour (00-23) format (for example, 3 p.m. = 15)

If the patient has not been discharged, leave this box blank.

Outpatient. Not required.

ITEM Description

17 **Status.**

Inpatient. Enter one of the following numeric codes to explain patient status as of the “through” date indicated in (Box 6) under “Statement Covers Period.”

<u>Code</u>	<u>Explanation</u>
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care.
04	Discharged/transferred to an Intermediate Care Facility
05	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
09	Admitted a inpatient to this hospital
20	Expired
30	Still a patient
40	Expired at home
41	Expired in a medical facility
42	Expired – place unknown
43	Discharged/transferred to a federal health care facility
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility, including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified Long Term Care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

66 Discharged/transferred to a Critical Access Hospital (CAH)

Outpatient. Not required.

ITEM **Description**

18-24 **Condition Codes. Inpatient/Outpatient.** Condition codes are used to identify conditions relating to this claim that may affect payer processing.

Although the PHC Medi-Cal claims processing system only recognizes the condition codes on the following pages, providers may include codes accepted by other payers. The PHC processing system ignores all codes not applicable to Medi-Cal.

Condition codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing for three condition codes, “A1”, “80”, and “82”, enter “80 in Box 18, “82” in Box 19, and “A1” in Box 20.

Applicable PHC codes are:

Other Coverage: enter code “80” if recipient has Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPS) and Health Maintenance Organizations (HMOs) that provide any of the recipient’s health care needs. Eligibility under Medicare or a Medi-Cal managed care plan is not considered OHC and is identified separately.

PHC requires that, with certain exceptions, providers must bill the recipient’s other health insurance coverage prior to billing PHC.

Emergency Certification: Enter code “81” if billing for emergency services. An Emergency Certification Statement must be attached to the claim or entered in the Remarks field (Box 80). The statement must be signed by the attending provider. It is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required prior authorization, such as emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist’s statement, describing the nature of the emergency, including relevant clinical information about the patient’s condition. A mere statement that an emergency existed is not sufficient. If the emergency Certification Statement will not fit in the Remarks field (Box 80), attach the statement to the claim.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

Family Planning/CHDP: enter code “AI” or “A4” if the services rendered are related to Family Planning (FP). Enter code “A1” if the services rendered are Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Leave blank if not applicable.

<u>Code</u>	<u>Description</u>
A1	EPSDT
A4	Family Planning
AI	Sterilization/Sterilization consent Form (PM330) must be attached if code “AI” is entered.

Outside Laboratory: Outpatient Only. Enter code “82” if this claim includes charges for laboratory work performed by a licensed laboratory. “Outside” laboratory (facility type “89”) refers to a laboratory not affiliated with the billing provider. State in the Remarks field (Box 80) that a specimen was sent to an unaffiliated laboratory.

Medicare Status: Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional; therefore, providers may leave this area of the Condition codes fields (Boxes 18024) blank. The Medicare status codes are:

Code	Description
Y0	Under 65, does not have Medicare coverage
Y1*	Benefits exhausted
Y2*	Utilization committee denial or physician non-certification
Y3*	No prior hospital stay
Y4*	Facility denial
Y5*	Non-eligible provider
Y6*	Non-eligible recipient
Y7*	Medicare benefits denied or cut short by Medicare intermediary
Y8	Non-covered services
Y9*	PSRO denial
Z1*	Medi-Medi Charpentier: Benefit Limitations
Z2*	Medi-Medi Charpentier: Rates Limitations
Z3*	Medi-Medi Charpentier: Both Rates and Benefit Limitations

*Documentation required. Refer to the State of California Medi-Cal Provider Manual *Medicare/Medi-Cal Crossover Claims: Outpatient Services* or *Inpatient Services* sections.

25-28 **Condition Codes.** The PHC claims processing system only recognizes condition codes entered in Boxes 18 – 24.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

- | <u>ITEM</u> | <u>Description</u> |
|-------------|---|
| 29 | ACDT State. Not required. |
| 30 | Unlabeled. Not required. |
| 31-34 A-B | Occurrence Codes and Dates. Inpatient/Outpatient: Occurrence codes and dates are used to identify significant events relating to a claim that may affect payer processing. |

Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. Although the PHC claims processing system will only recognize the following codes, providers may include codes and dates billed to other payers in Boxes 31 – 34. All codes not applicable to Medi-Cal will be ignored.

Applicable PHC codes are:

Enter code “04” (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter one of the following codes if the accident or injury was non-employment related:

<u>Code</u>	<u>Description</u>
01	Accident/medical coverage
02	No fault insurance involved – including auto accident/other
03	Accident/tort liability
05	Accident/no medical or liability coverage
06	Crime victim

In six-digit MMDDYY format, enter the date of accident/injury in the corresponding box.

Discharge date. Inpatient Only. In six digit MMDDYY format, enter code “42” and the date of hospital discharge with the date of discharge is different than the “Through” date in Box 6.

- | | |
|-----------|---|
| 35-36 A-B | Occurrence Codes and Dates. Not required |
|-----------|---|

- | | |
|-----|--------------------------------|
| 37A | Unlabeled. Not required |
|-----|--------------------------------|

Refer to the PHC Billing Limit section in the PHC Provider Manual for detailed information about delay reason codes and documentation requirements.

- | | |
|-----|---------------------------------|
| 37B | Unlabeled. Not required. |
|-----|---------------------------------|

- | | |
|----|---------------------------------|
| 38 | Unlabeled. Not required. |
|----|---------------------------------|

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

ITEM **Description**

39-41 A-D **Value Codes and Amount.** Patient's Share of Cost

Inpatient/Outpatient. Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence, starting with the lowest value.

Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the PHC claims processing system only recognizes codes "23" and "A1", providers may include codes and dates billed to other payers in Boxes 39 – 41. All other codes not applicable to PHC will be ignored.

Enter code "23" and the amount of the patient's Share of Cost for the procedure or service, if applicable. Do not enter a decimal point (.), dollar sign (\$), positive (+), or negative (-) sign. Enter full dollar amount and cents, even if the amount is even (for example, if billing for \$100, enter 10000 not 100). For more information about Share of Cost, see the *Share of Cost: UB-04 for Inpatient or Outpatient Services* section in the State of California Provider Manual.

Enter code A1 and the amount of the patients deductible amount.

42 **Revenue Code.**

Inpatient. Enter the appropriate revenue or ancillary code. Refer to the *Revenue Codes for Inpatient Services* section in the State of California Provider Manual. Ancillary codes are listed in the *Ancillary Codes* section in the State of California Provider Manual.

Outpatient. Not required.

Total Charges. Enter "001" on line 23, and enter the total amount on line 23, field 47. For multiple page claims, this is entered on the last page of the claim. Outpatient crossover claims billed for more than 15 line items must be split billed. See split billing section for special billing procedures.

43 **Description.**

Inpatient. Enter the description of the revenue or ancillary code used in Box 42. Refer to the *Revenue Codes for Inpatient Services* and *Ancillary Codes* sections in the State of California Medi-Cal Provider Manual for the appropriate description.

Note: If there are multiple pages of the claim, enter the page numbers on line 23 in this field.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

Outpatient. This field will help you separate and identify the descriptions of each service. The description must identify the particular service code indicated in the *HCPCS/Rate/HIPPS* Code field (Box 44). For more information, refer to the CPT-4 code book. This field is optional except when billing for physician-administered drugs.

Enter the National Drug Code (NDC) for Physician-Administered Drugs: Enter the product ID qualifier N4 followed by the 11-digit (no spaces or hyphens). Directly following the last digit of the NDC (no space), enter the two-character unit of measure qualifier followed by the numeric quantity. Refer to the *Physician-Administered Drugs-NDC: UB-04 Billing Instructions* section in the State of California Medi-Cal Provider Manual for more information.

Note: If there are multiple pages of the claim, enter the page numbers on line 23 in this field.

ITEM Description

44 HCPCS/Rate/HIPPS Code.

Inpatient. Not required.

Outpatient. Enter the applicable procedure or drug code (CPT-4 or HCPCS) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately.

Attach reports to the claim for “By Report” codes, complicated procedures (modifier 22) and unlisted services. Reports are not required for routine procedures.

Up to four modifiers may be entered. All modifiers must be billed immediately following the HCPCS code with no spaces.

For a listing of approved modifiers refer to Section III.E.

45 Service Date.

Inpatient. Not required.

Outpatient: Enter the date the service was rendered in six-digit, MMDDYY format, for example, June 24, 2004 = 062403. For “From-Through” billing instructions, refer to the UB-04 Special Billing Instructions for Outpatient Services section in the State of California Medi-Cal Provider Manual.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

ITEM **Description**

46 **Service Units.**

Inpatient. Accommodation Days. Enter the number of days of care by revenue code. Units of service are not required for ancillary services.

Outpatient: Enter the actual number of times a single procedure or item was provided for the date of service.

47 **Total Charges.**

Inpatient/Outpatient. In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). If an item is a taxable medical supply, include the applicable state and county sales tax.

Note: PHC cannot process credits or adjustments on the UB-04 form. Refer to the *CIF Completion and CIF Special Billing Instructions for Inpatient Services or Outpatient* sections in the State of California Medi-Cal Provider Manual.

Enter the “Total Charge” for all services on Line 23. Enter code 001 in Revenue Code field (Box 42) to indicate that this is the total charge line (refer to Item 42 on a previous page).

48 **Non-Covered Charges.** Not required

49 **Unlabeled.** Not required.

Note: Providers may enter up to 22 lines of detail date (Items 42-49). It is also acceptable to skip lines.

To delete a line, draw a thin line through the entire detail line using a blue or black ballpoint pen.

50A-C **Payer Name.**

Inpatient. Enter “I/P MEDI-CAL” to indicate type of claim and payer. Use capital letters only.

When completing Boxes 50-65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: PHC). Do not enter information on Lines A and B for other insurance or Medicare if payment was denied by these carriers.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

If PHC is the only payer billed, all information in Boxes 50 – 65 (excluding Box 56) should be entered on Line A.

Reminder: If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing PHC.

Outpatient: Enter “O/P MEDI-CAL” to indicate the type of claim and payer. Use capital letters only.

When completing Box 50 – 65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: PHC). Do not enter information on Lines A and B for other insurance or Medicare if payment was denied by these carriers.

When billing other insurance, the other insurance is entered on Line A of Box 50, with the amount paid by Other Coverage on Line A of Box 54 (Prior Payments). All information related to the PHC billing is entered on Line B of these boxes. Be sure to enter the corresponding prior payments on the correct line.

If PHC is the only payer billed, all information in Box 50 – 65 (excluding Box 56) should be entered on Line A.

Reminder: If the recipient has OHC, the insurance carrier must be billed prior to billing PHC.

ITEM **Description**

51A-C **Healthplan ID.** Not required

52A-C **Release of Information Certification Indicator.** Not required.

53A-C **Assignment of Benefits Certification Indicator.** Not required.

54A-B **Prior Payment (Other Coverage).** Enter the full dollar amount of payment received from OHC on the same line as the OHC “payer” (Box 50). Do not enter a decimal point (.), dollar sign (\$), positive (+), or negative (-) sign. Leave blank if not applicable.

Note: For instructions about completing this field for Medicare/Medi-Cal crossover recipients, refer to the *Medicare/Medi-Cal Crossover Claims: Inpatient or Outpatient Services* sections in the State of California Medi-Cal Provider Manual.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

ITEM Description

55A-C **Estimated Amount Due (Net amount Billed).** In full dollar amount, enter the difference between “Total Charges” and any deductions (for example, patient’s Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign (\$).

Total Charges (Minus) – Deductions	(Box 47) Revenue code 001 Share of Cost (Box 39, 40 or 41A-D/Value Code 23) and Other Coverage (Box 54A or B)
---------------------------------------	--

(Equals) = Net Billed (Box 55A – C)

56 **NPI.** Enter the National Provider Identifier (NPI).

57A-C **Other (Billing) Provider ID.** Not required.

58A-C **Insured’s Name.** If billing for an infant using the mother’s ID or for an organ donor, enter the Medi-Cal recipient’s name here and the patient’s relationship to the PHC recipient in Box 59 (Patient’s Relationship to Insured). See item 8B on a previous page in this section. This box is not required by PHC except under the two circumstances listed here.

59A-C **Patient’s Relationship to Insured.** If billing for an infant using the mother’s ID or for an organ donor, enter the code indicating the patient’s relationship to the PHC recipient (for example, “03” [CHILD] or “11” [DONOR]). See Item 8B on a previous page. This box is not required by PHC except under the two circumstances listed in Item 8B.

60A-C **Insured’s Unique ID.** Enter the recipient’s ID number (CIN) as it appears in the PHC ID card.

When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother’s ID number in this field.

61A-C **Group Name.** Not required.

62A-C **Insurance Group Number.** Not required.

63A-C **Treatment Authorization Codes.** For services requiring a Treatment Authorization Request (TAR), enter the PHC TAR Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR can cover the services billed on any one claim.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

ITEM Description

64A-C **Document Control Number.** Not required.

65A-C **Employer Name.** Not required.

66 **Diagnosis Code Header.** For claims with dates of services/dates of discharge on or after October 1, 2015, enter the ICD indicator “0” in the white space below the Diagnosis Code field (Box 66). No ICD indicator is required if the claims is submitted without a diagnosis code.

67 **Unlabeled (Use for primary diagnosis code).** Enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis, including fourth through seventh digits if present. Do not enter a decimal point when entering the code.

Present on admission (POA) indicator: Each diagnosis code may require a POA indicator that meeting Center for Medicare and Medicaid Services (CMS) standards. Enter POA indicators in the shaded area on the right side of Boxes 67-67Q.

<u>Code</u>	<u>Definition</u>
Y	Present at the time of inpatient admission
N	Not present at the time of inpatient admission
U	Documentation is insufficient to determine if condition is present on admission
W	Provider is unable to clinically determine whether condition was present on admission or not
Effective July 1, 2011	
1	Exempt from POA Reporting (UB-04 paper form only; not for use on 837)

67A **Unlabeled (Use for secondary diagnosis code).** If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code, including fourth through seventh digits if present. Do not enter a decimal point when entering the code.

Present on admission (POA) indicator: Each diagnosis code may require a POA indicator that meets CMS standards. Enter POA indicators in the shaded area on the right side of Boxes 67-67Q.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

Code	Definition
Y	Present at the time of inpatient admission
N	Not present at the time of inpatient admission
U	Documentation is insufficient to determine if condition is present on admission
W	Provider is unable to clinically determine whether condition was present on admission or not
Effective July 1, 2011	
1	Exempt from POA Reporting (UB-04 paper form only; not for use on 837)

ITEM **Description**

67B-Q **Unlabeled.** Not required.

68 **Unlabeled.** Not required.

69 **Admitting Diagnosis.** The encounter data system for the State Managed Care Entity requires a valid admit diagnosis for inpatient admissions on claim types 012x, 022x, and inpatient claims except 028x, 065x, 066x, and 086x. For admission on the 837 file, providers should use Loop 2300, Segment H101-01 or refer to page 35 of the 837 Institutional Companion Guide on the Partnership Healthplan website.

Footnote: Effective 10/1/15, any claims submitted to correct the admit, or other diagnosis, should be submitted through the CIF process.

70 **Patient Reason Diagnosis.** Not required.

71 **PPS Code.** Not required.

72 **External Cause of Injury Code.** Not required.

73 **Unlabeled.** Not required.

74 **Principal Procedure Code and Date.**

Inpatient: Enter the appropriate **ICD-10-CM** Volume 3 procedure code identifying the primary medical or surgical procedure. In six-digit MMDDYY format, enter the date the surgery or delivery was performed. Enter the **ICD-10-CM** Volume 3 procedure code, without periods or spaces between the numbers.

Outpatient: Not required.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

ITEM **Description**

74A-E **Other Procedure Codes and Dates.**

Inpatient: Enter the appropriate **ICD-10-CM** Volume 3 procedure code identifying the secondary medical or surgical procedure. Enter the ICD-10-CM Volume 3 code, without periods or spaces between the numbers.

Note: For OB vaginal or cesarean delivery and transplants, enter the appropriate **ICD-10-CM** Volume 3 procedure code in either Box 74 or 74 A – E.

Outpatient: Not required.

75 **Unlabeled.** Not required.

76 **Attending.**

Inpatient: In the first box, enter the attending physician's NPI. Do not use a group provider number. The attending physician's first and last names are not required.

Outpatient: In the first box, enter the provider number of the referring or prescribing physician. This field is mandatory for radiologists. If the physician is not a Medi-Cal provider, enter the state license number. Do not use a group provider number. The referring or prescribing physician's first and last names are not required.

77 **Operating.**

Inpatient: In the first box, enter the operating physician's NPI. Do not use a group provider number. The operating physician's first and last names are not required.

Outpatient: In the first box, enter the provider number of the facility in which the recipient resides or the physician actually providing services. Only one rendering provider number may be entered per claim form. Do not use a group provider number or state license number. The rendering physician's first and last names are not required.

ITEM **Description**

78 **Other.**

Inpatient: Use for admitting physician provider number. In the first box, enter the admitting physician's NPI. Do not use a group provider number. The admitting physician's first and last names are not required.

Outpatient: Not required.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT**

79 **Other.** Not required.

80 **Remarks.** Use this area for procedures that require additional information, justification or an Emergency Certification Statement. If this information will not fit in this field, attach to the claim.

81A-D **Code-Code.** Not required.

Split Billing Procedures:

Outpatient crossover claims billed for more than 15 line items for Part B services billed to PHC require billing on two or more separate UB-04 claim forms. This process is called “split billing.”

These claims require special billing procedures, as follows:

- Enter “001” on line 23 in the *Revenue Code* field (Box 42) and the sum of the charges amounts from the Medicare RA that correspond to the lines billed on the claim in the *Total Charges* field (Box 47) of each claim.
- The following information must be entered in the *Remarks* field (Box 80) on each split-billed claim form, or on an attachment to the claim:
 - ❖ Enter “SPLIT-BILLED.”
 - ❖ Enter the number of the claim (for example, “CLAIM 1 OF 2”).
- A separate copy of the entire Medicare RA must be submitted with each UB-04 claim.

Note: The amount entered on each split-billed claim is determined by the provider, but the sum of the amounts on each split-billed claim must equal the summary data on the Medicare RA.