

**DEPARTMENT OF
PUBLIC HEALTH AND HUMAN
SERVICES**

HEALTH RESOURCES DIVISION

**APR-DRG Claim Processing
and Editing Guide
September 2008**

Inpatient UB

**Medicaid Only
Required Fields are Highlighted**

1 Best Ever Hospital 104 Time Square Helena, MT 59601-0104		3 PAT 4806 4 TYPE 111 5 MED REC # Grisw97531 5 FED TAX NO		6 STATEMENT COVERS PERIOD FROM 122807 THROUGH 122907 7 9912345	
8 PATIENT NAME a Griswold, Ellen		9 PATIENT ADDRESS a 1313 Mockingbird Lane. Metropolis. MT 59601-1313			
10 BIRTHDATE 03/26/76	11 SEX F	12 DATE OF ADMISSION 13 HR 14 TYPE 15 SRC 122807 20 4 1	16 DHR 01	17 STAT 01	
18 19 20 21 22 23 24 25 26 27 28		29 ACCT STATE		30	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE	
34 OCCURRENCE DATE		35 OCCURRENCE CODE		36 OCCURRENCE SPAN FROM THROUGH	
37 OCCURRENCE DATE		38 OCCURRENCE CODE		39 OCCURRENCE SPAN FROM THROUGH	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
38 Griswold, Ellen 1313 Mockingbird Lane Metropolis, MT 59601-1313					
42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1 171	Nursery/Newborn Level I			2	1198 00
2 270	Gen Class Med/Surg Supplies			1	13 00
3 301	Chemistry			4	65 50
PAGE OF CREATION DATE 022208 TOTALS 1276 50					
50 PAYER NAME Medicaid		51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS
58 INSURED'S NAME Griswold, Ellen		59 P.PEL	60 INSURED'S UNIQUE ID 123456789	61 GROUP NAME	62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME		
66 V30 00	Y 774 6	W V05 3	1	68	
69 ADMIT DTY V30 00	70 PATIENT SEASONALITY	71 PPS CODE	72 ECL	73	
74 PRINCIPAL PROCEDURE CODE 99 55	75 OTHER PROCEDURE CODE	76 OTHER PROCEDURE DATE	77 ATTENDING NPI	78 QUAL	79 FIRST
74 OTHER PROCEDURE CODE	75 OTHER PROCEDURE DATE	76 OTHER PROCEDURE DATE	77 OPERATING NPI	78 QUAL	79 FIRST
80 REMARKS		81 C1C3 B3	82 282N0000X	78 OTHER NPI	79 QUAL
		81 C1C3	82	78 OTHER NPI	79 QUAL
		81 C1C3	82	78 OTHER NPI	79 QUAL
		81 C1C3	82	78 OTHER NPI	79 QUAL

UB-04 CMS-1450 OMB APPROVAL PENDING © 2005 NUBC

Fill Colors (shaded areas are slightly darker):
 Required Fields (light yellow)
 Conditional Fields (light green)
 Other (light blue)

Border Colors:
 Client Fields (blue)
 Provider Fields (orange)
 Billing Fields (purple)

NUBO Montana License # LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Required Fields Inpatient Claim

- FL1 – Provider name and address
- FL4 – Bill type
- FL6 – Statement covers period
- FL7 – Required if PASSPORT or Co-pay override indicator necessary
- FL8b – Patient's name
- FL12-15 – Admission information
- FL17 – Patient status
- FL42 – Revenue codes
- FL46 – Service units
- FL47 – Charges
- Line 23 – Creation Date

More Required Fields

- FL50 – Payer name
- FL 54 – Prior payments
- FL56 – NPI number
- FL58 – Insured's name
- FL60 – Insured's ID
- FL63 – Required if PA is necessary
- FL67A-Q Diagnosis and POA
- FL74a-e – ICD-9-CM Surgical procedure codes and dates if applicable
- FL76 – Attending Provider
- FL81cc - Taxonomy

Optional Fields

- FL3a – Control number
- FL 18-28 Condition codes (applicable to A4 and B3)
- FL31-36 – Occurrence codes
- FL39-41 – Value codes
- FL43 – Revenue code descriptions
- FL73 – Cost share indicator
- FL77-79 – Operating and other providers

Hospital Types

Critical Access Hospital

- New Provider Type = 74
 - No peer group
- PA required for:
 - Certain procedure codes (i.e. breast reduction)
 - Mental health
 - Certain DRGs (i.e. Mental Health, transplants)
 - Interim claims
 - Without PA for the above claim will deny
- Detox services over 4 days require PA
 - Claim will not deny however payment will be recouped by SURS
- No base price
 - Paid by hospital specific cost to charge ratio (CCR)

PPS Hospitals

- Peer Groups
 - 1, 2, 3 = Instate facilities
 - 4 = psychiatric units and facilities
 - 8 = Rehab and LTCH facilities (may be in or out of state)
- PA required for:
 - Certain procedure codes (i.e. breast reduction)
 - Mental health
 - Certain DRGs (i.e. Mental Health, transplants)
 - Interim claims
 - Without PA for the above claim will deny
- Detox services over 4 days require PA
 - Claim will not deny however payment will be recouped by SURS
- Base price
 - Peer group 1, 2, 3 and 4 = \$4129
 - Peer group 8 = \$9092

Border Hospitals

- Peer Groups
 - 5 = Border facilities
 - 8 = Rehab and LTCH facilities
 - 6 = Centers of Excellence (may be border or out of state)
- PA required for:
 - Certain procedure codes (i.e. breast reduction)
 - Mental health
 - Certain DRGs (i.e. Mental Health, transplants)
 - Interim claims
 - Without PA for the above claim will deny
- Detox services over 4 days require PA
 - Claim will not deny however payment will be recouped by SURS
- Base price
 - Peer group 5 = \$4129
 - Peer group 8 = \$9092
 - Peer group 6 = \$6890

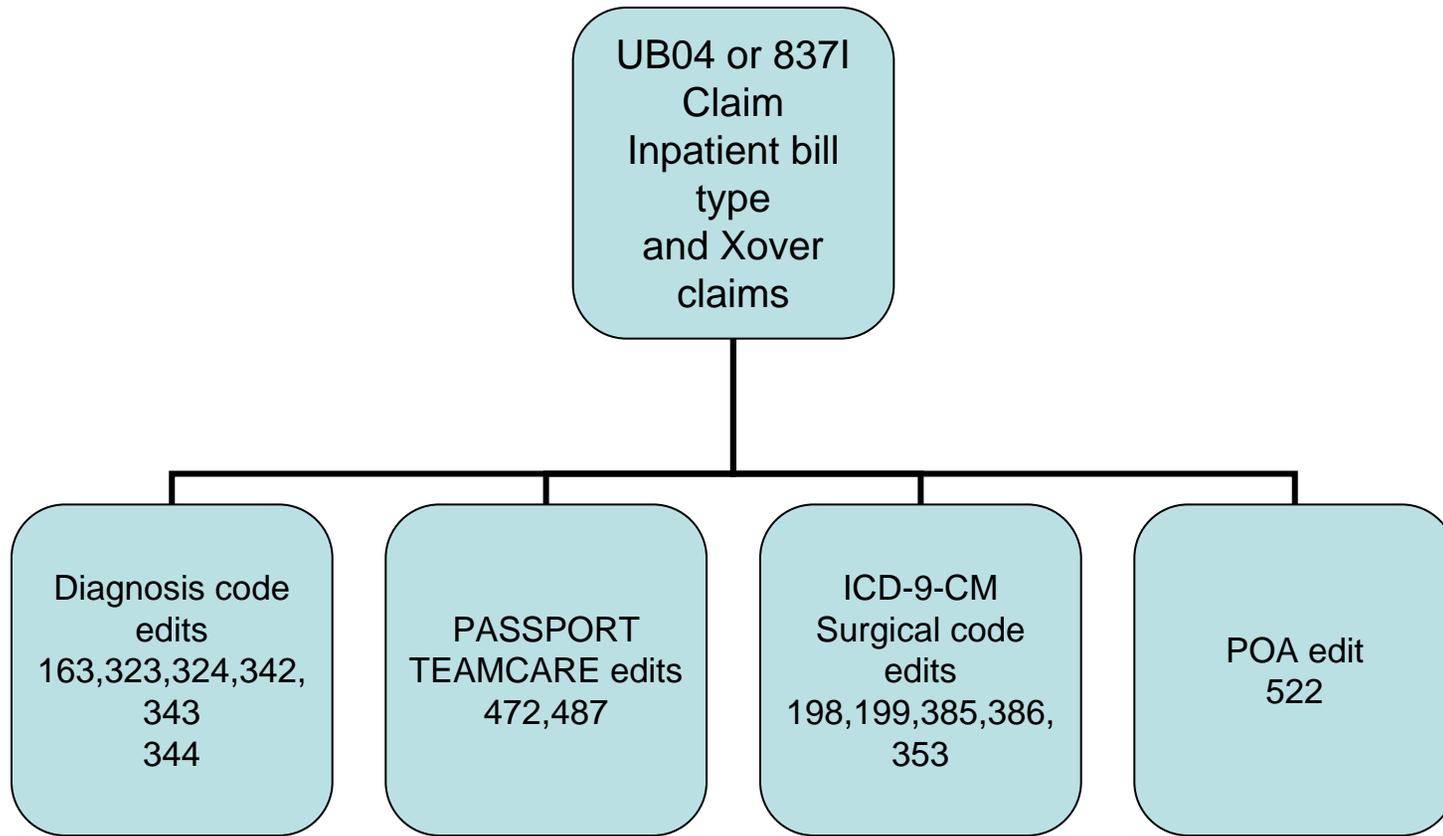
Out of State Hospitals

- Peer Groups
 - 9 = Out of State
 - 8 = Rehab and LTCH facilities
 - 6 = Centers of Excellence
- All Out of State Facilities require a PA regular services
 - Without the PA – claim will pay 50% of the DRG
- Mandatory PA required for:
 - Certain procedure codes (i.e. breast reduction)
 - Mental health
 - Certain DRGs (i.e. Mental Health, transplants)
 - Interim claims
 - Without PA for the above claim will deny
- Detox services over 4 days require PA
 - Claim will not deny however payment will be recouped by SURS
- Base price
 - Peer group 9 = \$4129
 - Peer group 8 = \$9092
 - Peer group 6 = \$6890

Centers of Excellence

- Peer Groups
 - 6 = Centers of Excellence (border or out of state only)
- All Centers of Excellence require a PA regular services
 - Without the PA – claim will pay 50% of the DRG
- Mandatory PA required for:
 - Certain procedure codes (i.e. breast reduction)
 - Mental health
 - Certain DRGs (i.e. Mental Health, transplants)
 - Interim claims
 - Without PA for the above claim will deny
- Detox services over 4 days require PA
 - Claim will not deny however payment will be recouped by SURS
- Base price
 - Peer group 6 = \$6890

Claim Process



Diagnosis Edits

- Diagnosis Code Edits
 - 163-Diagnosis not present
 - Reason code 21-Remark code MM81This diagnosis is invalid
 - 323-Diagnosis age mismatch
 - Reason code 9-Diagnosis is not consistent with the patient's age
 - 324-Diagnosis not allowed for client's sex
 - Reason code 10-Diagnosis is inconsistent with the patient's gender
 - 342-Diagnosis requires medical review
 - Reason code 125-Remark code N10-claim adjusted based on findings of a review organization
 - 343-Diagnosis non-covered
 - Reason code 167-this diagnosis is not covered
 - 344-Diagnosis not on file
 - Reason code 15—Remark code M81-this diagnosis is missing or invalid

PASSPORT and TEAMCARE

- **PASSPORT/TEAMCARE Edits**
 - **472-PASSPORT number missing/invalid**
 - Reason code 15-Remark code M68-missing/incomplete/invalid attending or referring physician identification
 - **487-TEAMCARE requirement not met**
 - Reason code 15-Remark code M68-missing/incomplete/invalid attending or referring physician identification

ICD-9-CM Surgical Codes

- ICD-9-CM surgical code edits
 - 198-surgical code present, no surgical date
 - Reason code 16-Remark code MA66-missing/incomplete/invalid principal procedure code or date
 - 199-surgical procedure missing, date present
 - Reason code 16-Remark code N65-procedure code cannot be determined or was not on file
 - 385-primary surgical procedure not valid
 - Reason code B18-Remark code MA66- missing/incomplete/invalid principal procedure code or date
 - 386-secondary surgical procedure not valid
 - Reason code B18-Remark code MA67- missing/incomplete/invalid other procedure code or date
 - 353-procedure requires PA
 - Reason code 62-payment denied for absence of or exceeded PA

POA Indicator

- Report on 837I Loop 2300-Segment K3, Data Element 01 K3(is known as File information or Claim Information)
- The POA indicator is reported on the paper UB04 in the eighth digit (shaded area) of FL67 for the principal diagnosis and in the eight digit (shaded area) of FL67A-Q for each secondary diagnosis
- Your claim will deny after October 1, 2008 if there is not a valid POA indicator for each diagnosis

POA Valid Values

- Codes and definitions
- 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
- 1 = Exempt from reporting

Group Using APR-DRG

Unable to Group
edit 520

PA required
edit 460,461,463,464,466,471, 473

POA and Ungroupable Edits

- POA
 - 522-present on admission indicator is invalid
 - Reason code D18-Remark code N434-missing/incomplete/invalid POA
- Unable to Group
 - 520-ungroupable-DRG is 955 or 956
 - Reason code A8-claim denied ungroupable DRG

Prior Authorization Edits

- PA Edits
 - 460-PA missing or invalid
 - Reason code 62-Remark code M62-Missing/incomplete/invalid treatment authorization code
 - 461-PA pending
 - Reason code 62-payment denied for absence of or exceeded authorization
 - 463-Client ID does not match PA
 - Reason code 15-Remark code N54-claim information is inconsistent with precertification/authorized services
 - 464-Provider ID does not match PA
 - Reason code 15-submitted authorization number is missing, invalid or does not apply to the provider
 - 466-Units billed exceed number of units authorize
 - Reason code 62-Remark code N54-Claim information is inconsistent with precertification/authorized services
 - 471-PA denied
 - Reason code 39-services denied at the time authorization was requested
 - 473-PA used
 - Reason code 62- payment denied for absence of or exceeded authorization

Interim Claims

```
graph TD; A[Interim Claims] --- B[Bill type 114 or 115  
Edit 523]; B --- C[Claim less than 30 days  
Edit 524]; C --- D[Interim PA missing or invalid  
Edit 525];
```

Bill type 114 or 115
Edit 523

Claim less than 30 days
Edit 524

Interim PA missing or invalid
Edit 525

Interim Claims

- Interim Claims
 - Bill type 114 or 115 – edit 523- invalid frequency on interim claim
 - Reason code 16-Remark code MA30- Missing/incomplete/invalid type of bill
 - Claim less than 30 days – edit 524 –interim claim LOS <30 days
 - Reason code 16-Remark code MA59- missing/incomplete/invalid “to” date of service
 - Interim PA missing/or invalid – 460-PA missing or invalid
 - Reason code 62-Remark code M62- Missing/incomplete/invalid treatment authorization code

Other Edits

- Claims will still be subject to the usual edits
 - Invalid recipient number
 - Invalid NPI and/or taxonomy
 - From and To date LOS doesn't match units on bed revenue codes
 - Invalid Bill Type

Key Contacts After Oct 1st

- **ACS, Inc. Provider Relations; (800) 624-3958 in-state/out of state; (406) 442-1837 Helena; mtprhelpdesk@acs-inc.com**
- **Kathi Salome, Claims Resolution Specialist; (406) 444-7002; ksalome@mt.gov**
- **Stacy Roope, Hospital Program Officer; (406) 444-7018; sroope@mt.gov**
- **Rey Busch, Hospital Program Officer; (406) 444-4834; rbusch@mt.gov**
- **Mary Patrick RN, Case Management; (406) 444-0061 mpatrick@mt.gov for PA of Detox Services**
- **MPQHF, Prior Authorization, Transplant & Utilization Review; (800) 262-1545 X5850 In and out of state
(406) 443-4020 X5850 Helena**