Obstetrics: UB-04 Billing Examples for Inpatient Services – DRG Payment Method

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Examples in this section are to help providers submit obstetric (OB) and newborn inpatient services claims with adequate detail so claims reimburse at the appropriate level under the diagnosis-related groups (DRG) payment methodology.

‹‹Refer to the *Obstetrics: Revenue Codes and Billing Policy for Designated Public Hospitals* section of this manual for detailed policy information.›› Refer to the *UB-04 Completion: Inpatient Services* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts. If requested information does not fit neatly in the *Remarks* field (Box 80) of the claim, type it on an 8½ by 11-inch sheet of paper and attach it to the claim. In addition, for claims that will be reimbursed under the DRG payment methodology:

The primary reason for admission should be placed in the primary diagnosis field (Box 67) of the *UB-04* claim form.

The newborn claim must be submitted independently of the mother's claim for delivery. A claim submitted with both delivery and neonatal services together will be denied.

Providers must ensure that interim claims (claims exceeding 29 days) submitted on various dates contain consistent Benefits Identification Card (BIC) numbers. The newborn's unique Medi-Cal BIC number is preferred on claims for the newborn, but the mother's BIC number is acceptable. Interim claims for the same neonatal stay with both the newborn's and mother's number, or numbers that disagree with the previous interim claim, will be denied.

Electronic Claims: Baby Using Mother's ID Number

For electronic claim submissions, a statement indicating "baby using mother's ID" must be entered in the NTE segment of the 837I v.5010 electronic claim.

Cesarean Delivery of Acutely Sick Newborn: DRG-Reimbursed Hospital

Figures 1a and 1b. Cesarean delivery of acutely sick newborn. Diagnosis-related groups (DRG)-reimbursed hospital.

This is a sample only. Please adapt to your billing situation.

Case Description

A mother, who was admitted on October 1, delivers an acutely sick newborn by cesarean section on October 2. The baby develops tachycardia on October 2. The newborn is jaundiced and has a fever. Blood cultures are drawn and I.V. antibiotics are started. The newborn is given phototherapy. The mother is discharged October 5 and the baby is discharged October 8.

Overview of Policy

Because the newborn is ill, his hospital stays requires an admission *Treatment Authorization Request* (TAR). ‹‹Services for the acutely sick newborn are separately reimbursable and must be billed on a claim separate from the mother's claim.››

Mother's Claim

Figure 1a: Mother's claim.

Enter the two-digit facility type code "11" and the one-character claim frequency code "1" as "111" in the *Type of Bill* field (Box 4).

Enter the date of the mother's admission, October 1, 2015, in six-digit format (100115) in the *Admission Date* field (Box 12). Enter the 4 p.m. hour of admission in military terms (16) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14), enter the "type" of admission. In this case, the "1" indicates an emergency admit.

The total length of the mother's stay is entered in the *Statement Covers Period* field (Box 6). Enter the day of admission (100115) as the "From" date and the day of discharge (100515) as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 11 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the mother was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 thru 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 152 is entered in the *Revenue Code* field (Box 42) to bill OB-related room and board services for the mother. Enter the description of code 152 (room and board, ward, OB) in the *Description* field (Box 43). Enter a 4 in the *Service Units* field (Box 46) to indicate the number of days the mother stayed in the hospital. Do not count the day of discharge.

All ancillary services are listed. Units of service are not required for ancillary services.

Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Enter the appropriate primary diagnosis code in Box 67. In this case, ICD-10-CM diagnosis code Z37.0 representing single live newborn is entered in primary diagnosis field Box 67 without decimal points. Secondary ICD-10-CM diagnosis code O82, (encounter for cesarean delivery without indication) is entered as well:

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable diagnosis codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, diagnosis code Z37.0 is exempt from POA reporting requirements so no POA indicator is present. Because no illness was detected when the mother was admitted, the POA indicator "N" (no) is entered for diagnosis code O82.

Enter the principal ICD-10-PCS code 10D00Z1 (extraction of products of conception, low, open approach) in the *Principal Procedure* field (Box 74).

The date the procedure was performed, October 2, 2015, is entered as 100215 adjacent to the procedure.

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

Enter the attending physician's NPI in the *Attending* field (Box 76).
Enter the operating physician's NPI in the *Operating* field (Box 77).
Enter the admitting physician's NPI in the first *Other* field (Box 78).

Acutely Sick Newborn's Claim

Figure 1b: Acutely sick newborn's claim.

Enter the two-digit facility type code "11" and the one-character claim frequency code "1" as "111" in the *Type of Bill* field (Box 4).

Enter the date of delivery, October 2, 2015, in six-digit format (100215) as the date of admission for the newborn in the *Admission Date* field (Box 12). Enter the newborn's noon hour of birth as the hour of admission in military terms (12) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "1" indicates an emergency admit.

The length of time the baby stays at the hospital is entered in the *Statement Covers Period* field (Box 6). The date of the baby's admission (100215) is entered as the "From" date and the day of the baby's discharge (100815) is entered as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 10 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this scenario, the "01" indicates the baby was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 thru 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

The sick-newborn services rendered require an approved TAR and are billed with revenue code 172. Enter code 172 in the *Revenue Code* field (Box 42) and the description of code 172 (nursery newborn, Level II) in the *Description* field (Box 43). Enter a 6 in the *Service Units* field (Box 46) to indicate billing six hospital days for the baby. The day of discharge is not reimbursable.

Note: Reimbursement for acute care days billed with revenue code 172 begins the day of the newborn's admission. This claim bills for services rendered to the sick newborn beginning October 2.

All ancillary services are listed. Units of service are not required for ancillary services.

Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Type the mother's name (the insured party) in the *Insured's Name* field (Box 58). Enter code 03 in the *Patient's Relationship to Insured* field (Box 59) to designate that the recipient is the insured's child who is using his mother's ID number, which is entered in Box 60.

Enter the entire 11-digit TAR control number in the *Treatment Authorization Codes* field (Box 63). Code 172 services rendered to an acutely sick newborn require an admission TAR.

Enter the appropriate primary diagnosis code(s) in Box 67. In this case, ICD-10-CM diagnosis code Z38.01 represents a single liveborn baby born in a hospital, delivered by cesarean section and is entered on the claim as Z3801. The secondary diagnosis code, R78.81, represents bacteremia of newborn and is listed on the claim as R7881. Add the other applicable secondary diagnosis codes:

P19.1: Metabolic academia in newborn first noted during labor

P59.9: Neonatal jaundice, unspecified

Note: Claims submitted for services rendered to a newborn require at least one diagnosis code. Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable diagnosis codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate Z38.0 thru Z38.8 code for the birth episode.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, Z38.01 is exempt from POA reporting. The baby's other conditions present at birth are considered to be present on admission and require a "Y" (yes) POA.

Procedures were also performed on the newborn. ICD-10-PCS code 3E03329, which represents injection of an antibiotic, is entered in the *Principle Procedure* field (Box 74). The other applicable secondary procedures codes are added and the date of each procedure is entered adjacent to the code in six-digit format.

6A600ZZ: Phototherapy of skin, single

05HY33Z: Insertion of infusion device in upper vein, percutaneous

BW0MZZZ: Imaging, plain radiography, whole body, infant

Note: No procedure code related to the services rendered to the mother should appear on the newborn's claim. Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

Enter the attending physician's NPI in the *Attending* field (Box 76).
Enter the operating physician's NPI in the *Operating* field (Box 77).
Enter the admitting physician's NPI in the first *Other* field (Box 78).

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

3a PAT. CNTL #	b. MED. REC. #	4 TYPE OF BILL	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH
		111		100115	100515

8 PATIENT NAME: b DOE, JANE

9 PATIENT ADDRESS

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 CONDITION CODES
08241986	F	100115	16	1		11	01	YO

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
152	ROOM & BOARD, WARD, OB			4	360000	
250	GENERAL PHARMACY				11025	
300	GENERAL LABORATORY				49375	
720	LABOR ROOM/DELIVERY GEN.				64000	
710	RECOVERY ROOM GENERAL				43500	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	527900	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
I/P MEDI-CAL					527900	0123456789

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		90000000A95001		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: 0 | 67 Z370 | A O82 | N

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI

74 PRINCIPAL PROCEDURE CODE	DATE
10D00Z1	100215

	NPI	QUAL	LAST	FIRST
76 ATTENDING	1234567890			
77 OPERATING	2345678901			
78 OTHER	3456789012			
79 OTHER				

80 REMARKS | 81CC

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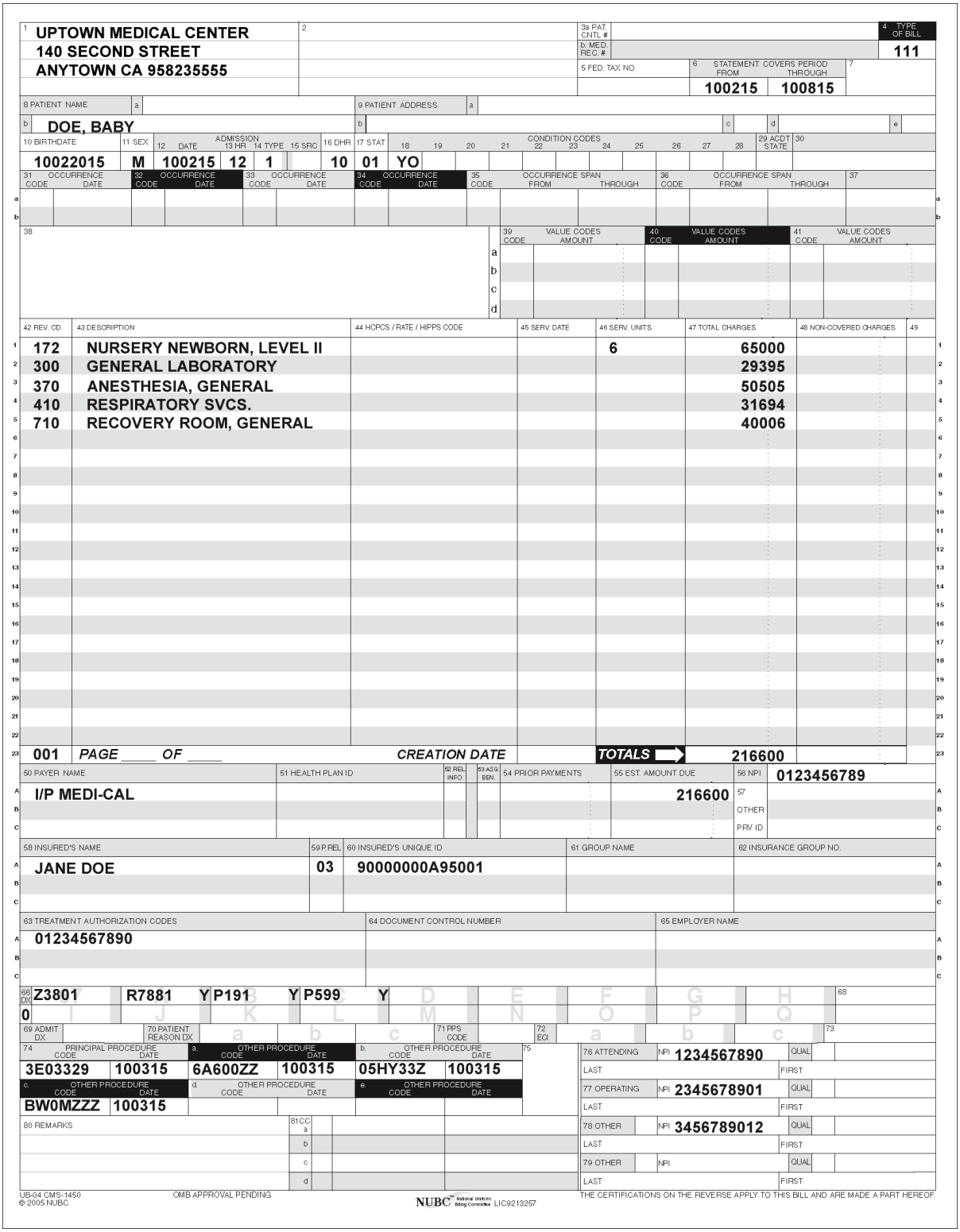
Figure 1a: Cesarean Delivery of Acutely Sick Newborn.
Mother's Claim. DRG-Reimbursed Hospital.



1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2	3a PAT. CNTL #	4 TYPE OF BILL: 111
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD: FROM 100215 THROUGH 100815

8 PATIENT NAME	9 PATIENT ADDRESS
b DOE, BABY	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
10022015	M	100215	12	1		10	01	YO		

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

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a					
	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	172	NURSERY NEWBORN, LEVEL II			6	65000		
2	300	GENERAL LABORATORY				29395		
3	370	ANESTHESIA, GENERAL				50505		
4	410	RESPIRATORY SVCS.				31694		
5	710	RECOVERY ROOM, GENERAL				40006		
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS	216600		

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 I/P MEDI-CAL					216600	0123456789	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A JANE DOE	03	90000000A95001		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 01234567890		

66 DX	A	B	C	D	E	F	G	H	68
	Z3801	R7881 Y	P191 Y	P599 Y					
	0	I J	K	L	M	N	O	P Q	

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
3E03329	100315	6A600ZZ	100315	05HY33Z	100315	

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE
BW0MZZZ	100315				

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI 1234567890	QUAL	
LAST		FIRST	
77 OPERATING	NPI 2345678901	QUAL	
LAST		FIRST	
78 OTHER	NPI 3456789012	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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Figure 1b. Cesarean Delivery.
Acutely Sick Newborn's Claim. DRG-Reimbursed Hospital.

Multiple Births of Twins with Differing Dates of Birth: DRG-Reimbursed Hospital

Figures 2a, 2b and 2c. Multiple births of twins with differing dates of birth. Diagnosis-related groups (DRG)-reimbursed hospital.

These are samples only. Please adapt to your billing situation.

Case Description

A mother, who is admitted on October 1, delivers her first twin (well newborn) vaginally on October 2 and her second twin (sick newborn) vaginally on October 3. The mother and her well newborn twin are discharged on October 5. The sick newborn twin is discharged on October 8.

Overview of Policy

The mother's hospital stay and services for the healthy twin do not require TARs. The second twin is admitted to the Neonatal Intensive Care Unit (NICU) and requires an approved admit TAR for services commencing with the date of admission. Separate claims are required for each patient: the mother, the healthy twin and the sick twin.

Note: *Welfare and Institutions Code* (W&I Code), Section 14132.42 prohibits hospitals from discharging a mother before 48 hours following a normal vaginal delivery, unless early discharge is agreed upon by both the treating physician and the mother. If the mother is discharged early, a post-discharge follow-up visit must be made available to the mother and her newborn within 48 hours of discharge.

Mother's Claim

Figure 2a: Mother's claim.

Enter the two-digit facility type code "11" and one-character claim frequency code "1" as "111" in the *Type of Bill* field (Box 4).

Enter the date of the mother's admission, October 1, 2015, in six-digit format (100115) in the *Admission Date* field (Box 12). Enter the 9 p.m. hour of admission in military terms (21) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "1" indicates an emergency admit.

The total length of the mother's stay is entered in the *Statement Covers Period* field (Box 6). Enter the day of admission (100115) as the "From" date and the day of discharge (100515) as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 11 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the mother was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 thru 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 152 is entered in the *Revenue Code* field (Box 42) to bill OB-related room and board services for the mother. Enter the description of code 152 (room and board, ward, OB) in the *Description* field (Box 43). Enter a 4 in the *Service Units* field (Box 46) to indicate the number of days the mother stayed in the hospital. Do not count the day of discharge.

All ancillary services are listed. Units of service are not required for ancillary services.

Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Enter an appropriate primary diagnosis code in Box 67. In this case, ICD-10-CM diagnosis code O30.043 represents a twin pregnancy. Diagnosis code Z37.2 indicates twins, both liveborn. The codes are entered on the claim without decimals.

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable diagnosis codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, diagnosis code O30.043 indicates the mother was carrying twins on admission and requires a "Y" (yes) POA. Diagnosis code Z37.2 is exempt from POA reporting so no POA indicator is present.

ICD-10-PCS code 10D07Z3 (low forceps operation) is entered in the *Principal Procedure* field (Box 74). Also included is ICD-10-PCS code 0UQMXZZ (repair of other current obstetric laceration). They are entered respectively on the claim without a decimal point. The date of the procedure, October 2, 2015, is entered as 100215 adjacent to both procedure codes.

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

When billing claims involving multiple births, the multiple births and specific birth date for each newborn should be included in the *Remarks* field (Box 80).

Enter the attending physician's NPI in the *Attending* field (Box 76).
Enter the operating physician's NPI in the *Operating* field (Box 77).
Enter the admitting physician's NPI in the first *Other* field (78).

Healthy Twin's Claim

Figure 2b: Healthy Twin's Claim.

Enter the two-digit facility type code "11" and one-character claim frequency code "1" as "111" in the *Type of Bill* field (Box 4).

Enter the date of the first healthy twin's delivery, October 2, 2015, in six-digit format (100215) as the date of admission in the *Admission Date* field (Box 12). Enter the twin's 11 p.m. hour of birth as the hour of admission in military terms (23) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "4" indicates a newborn admit.

The length of time the baby stays in the hospital is entered in the *Statement Covers Period* field (Box 6). The day of birth (100215) is entered as the "From" date and the day of discharge (100515) is entered as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is noon (12). Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this scenario, the "01" indicates the baby was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 thru 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 171 is entered in the *Revenue Code* field (Box 42) and the description of code 171 (nursery newborn, Level I) in the *Description* field (Box 43). Enter a 3 in the *Service Units* field (Box 46) to indicate number of days the baby stayed in the hospital. Do not include the day of discharge.

All ancillary services are listed. Units of service are not required for ancillary services.

Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Type the mother's name (the insured party) in the *Insured's Name* field (Box 58). Enter code 03 in the *Patient's Relationship to Insured* field (Box 59) to designate that the recipient is the insured's child who is using his mother's ID number, which is entered in Box 60.

Enter an appropriate primary ICD-10-CM code in Box 67. In this case, code Z38.30 represents an unspecified twin, born in a hospital and delivered without mention of cesarean delivery. ICD-10-CM diagnosis code Z3A.37 represents gestational age of pregnancy of 37 weeks. The codes are entered on the claim as Z3830 and Z3A37.

Note: Claims submitted for services rendered to a baby require at least one diagnosis code. Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable diagnosis codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate Z38.0 thru Z38.8 code for the birth episode.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, Z38.30 is exempt from POA reporting requirements. For diagnosis code Z3A.37, the twin is healthy so the POA indicator is an "N" (no).

No procedures were performed on the newborn, so no procedure code is required.

Note: No procedure code related to the services rendered to the mother should appear on the baby's claim. Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

When billing claims involving multiple births, the multiple births and the specific birth dates for both twins are included in the *Remarks* field (Box 80) on both twins' claims.

Enter the attending physician's NPI in the *Attending* field (Box 76).
Enter the operating physician's NPI in the *Operating* field (Box 77).
Enter the admitting physician's NPI in the first *Other* field (Box 78).

NICU-Admitted Twin's Claim

Figure 2c: Second twin's claim (sick newborn requiring NICU services).

Enter the two-digit facility type code "11" and one-character claim frequency code "1" as "111" in the *Type of Bill* field (Box 4).

Enter the date of the second twin's delivery, October 3, 2015, in six-digit format (100315) as the date of admission in the *Admission Date* field (Box 12). Enter the twin's 1 a.m. hour of birth as the hour of admission in military terms (1) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "1" indicates an emergency admit.

The length of time the baby stays in the hospital is entered in the *Statement Covers Period* field (Box 6). The day of birth (100315) is entered as the "From" date and the day of discharge (100315) is entered as the "Through" date. Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 3 p.m. (15). Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this scenario, the "01" indicates the baby was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 thru 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

The NICU services for the second twin must be billed using revenue code 174 on a claim separate from the mother. Enter code 174 in the *Revenue Code* field (Box 42) and the description of code 174 (nursery newborn; Level IV) in the *Description* field (Box 43). Enter a 5 in the *Service Units* field (Box 46) to indicate five days of NICU care. Do not include the day of discharge.

All ancillary services are listed. Units of service are not required for ancillary services.

Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Type the mother's name (the insured party) in the *Insured's Name* field (Box 58). Enter code 03 in the *Patient's Relationship to Insured* field (Box 59) to designate that the recipient is the insured's child who is using his mother's ID number, which is entered in Box 60.

Enter the entire 11-digit TAR control number in the *Treatment Authorization Codes* field (Box 63). NICU services require an approved admit TAR for reimbursement of the days being billed, commencing with the date of admission.

Enter an appropriate primary ICD-10-CM code in Box 67. In this case, code Z38.30 represents an unspecified twin, born in a hospital and delivered without mention of cesarean delivery. ICD-10-CM diagnosis code Z3A.37 represents gestational age of pregnancy of 37 weeks. The codes are entered on the claim as Z3830 and Z3A37.

Code P15.9 represents unspecified birth trauma for the newborn, code Q89.09 represents aberrant spleen and code I45.5 represents intraventricular block. Enter without decimal points as P159, Q8909 and I455 respectively.

Note: Claims submitted for services rendered to a newborn require at least one diagnosis code. Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable diagnosis codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate Z38.0 thru Z38.8 code for the birth episode.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. Codes Z38.30 and Q89.09 are exempt from POA reporting requirements. All other diagnosis codes listed require a "Y" (yes) POA.

Enter ICD-10-PCS code 8E01XY7 (other procedure, nervous system, external) in the *Principal Procedure* field (Box 74). Also enter ICD-10-PCS code 6A600ZZ (phototherapy of skin, single) in the *Other Procedure* field. The date of the procedure is listed in six-digit format adjacent to each procedure. In this example the procedures were performed on 100315.

Note: No procedure code related to the services rendered to the mother should appear on the baby's claim. Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

When billing claims involving multiple births, the multiple births and the specific birth dates for both twins are included in the *Remarks* field (Box 80) on both twins' claims.

Enter the attending physician's NPI in the *Attending* field (Box 76).
Enter the operating physician's NPI in the *Operating* field (Box 77).
Enter the admitting physician's NPI in the first *Other* field (Box 78).

Field	Entry
1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555
2	
3a PAT. CNTL #	
b. MED. REC. #	
4 TYPE OF BILL	111
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM	100115
6 STATEMENT COVERS PERIOD THROUGH	100515
8 PATIENT NAME	DOE, JANE
9 PATIENT ADDRESS	
10 BIRTHDATE	08241986
11 SEX	F
12 ADMISSION DATE	100115
13 HR	21
14 TYPE	1
15 SRC	
16 DHR	11
17 STAT	01
18 CONDITION CODES	YO

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
152	ROOM & BOARD, WARD, OB			4	280000		
250	GENERAL PHARMACY				11025		
300	GENERAL LABORATORY				49375		
720	LABOR ROOM/DELIVERY GEN.				64000		
710	RECOVERY ROOM GENERAL				43500		
001	PAGE ____ OF ____	CREATION DATE		TOTALS	447900		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
I/P MEDI-CAL					447900	0123456789

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		90000000A95001		

63 TREATMENT AUTHORIZATION CODES / 64 DOCUMENT CONTROL NUMBER / 65 EMPLOYER NAME: (blank)

66 DX: 0 — 67: O30043 Y — A: Z372

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE
10D07Z3	100215	0UQMXZZ	100215

Provider	NPI
76 ATTENDING	1234567890
77 OPERATING	2345678901
78 OTHER	3456789012
79 OTHER	

80 REMARKS:
MULTIPLE BIRTHS:
NEWBORN#1 DEL 100215 WELL BABY
NEWBORN#2 DEL 100315 SICK BABY

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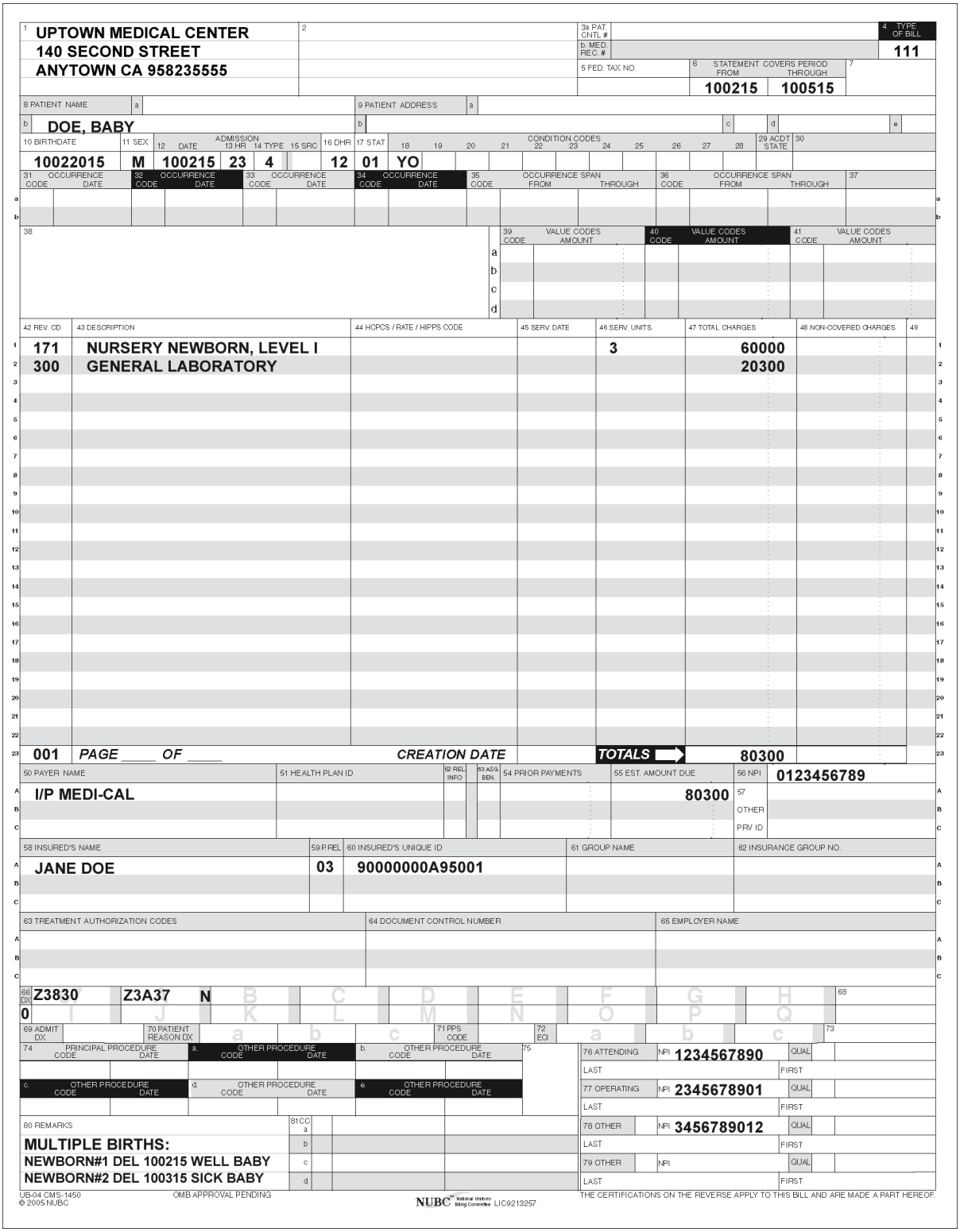
Figure 2a: Multiple Births of Twins With Differing Dates of Birth.
Mother's Claim. DRG-Reimbursed Hospital.



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 111

6 STATEMENT COVERS PERIOD: FROM 100215 THROUGH 100515

8 PATIENT NAME: DOE, BABY

10 BIRTHDATE: 10022015 | 11 SEX: M | 12 ADMISSION DATE: 100215 | 13 HR: 23 | 14 TYPE: 4 | 16 DHR: 12 | 17 STAT: 01 | CONDITION CODES: YO

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
171	NURSERY NEWBORN, LEVEL I			3	60000	
300	GENERAL LABORATORY				20300	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	80300	

50 PAYER NAME: I/P MEDI-CAL | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE: 80300 | 56 NPI: 0123456789

58 INSURED'S NAME: JANE DOE | 59 P REL: 03 | 60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: Z3830 | Z3A37 | N

76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901
78 OTHER NPI: 3456789012

80 REMARKS:
MULTIPLE BIRTHS:
NEWBORN#1 DEL 100215 WELL BABY
NEWBORN#2 DEL 100315 SICK BABY

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Figure 2b: Multiple Births of Twins With Differing Dates of Birth.
Healthy Twin's Claim. DRG-Reimbursed Hospital.

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 111

6 STATEMENT COVERS PERIOD: FROM 100315 THROUGH 100815

8 PATIENT NAME: DOE, BABY

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES	29 ACDT STATE	30
10032015	M	100315	1	1		15	01	YO		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
174	NURSERY NEWBORN, LEVEL IV			5	3216000	
250	GENERAL PHARMACY				300000	
270	MEDICAL/SURGICAL SUPPLIES				150025	
300	GENERAL LABORATORY				40000	
320	GENERAL LABORATORY				100075	
320	BLOOD GENERAL				20000	
320	RESPIRATORY SERVICES				30000	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	3856100	

50 PAYER NAME: I/P MEDI-CAL
55 EST. AMOUNT DUE: 3856100
56 NPI: 0123456789

58 INSURED'S NAME: JANE DOE
59 P REL: 03
60 INSURED'S UNIQUE ID: 90000000A95001

63 TREATMENT AUTHORIZATION CODES: 01234567890

66 DX: Z3830 Z3A37 Y P159 Y Q8909 I455 Y
0

74 PRINCIPAL PROCEDURE CODE DATE: 8E01XY7 100315
a. OTHER PROCEDURE CODE DATE: 6A600ZZ 100315

76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901
78 OTHER NPI: 3456789012

80 REMARKS:
MULTIPLE BIRTHS:
NEWBORN#1 DEL 100215 WELL BABY
NEWBORN#2 DEL 100315 SICK BABY

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Figure 2c: Multiple Births of Twins With Differing Dates of Birth. NICU-Admitted Twin's Claim. DRG-Reimbursed Hospital.

Vaginal Delivery Prior to Hospital Admission: DRG-Reimbursed Hospital

Figures 3a and 3b. Vaginal delivery prior to hospital admission. Diagnosis-related groups (DRG)-reimbursed hospital.

This is a sample only. Please adapt to your billing situation.

Case Description

A mother vaginally delivers a healthy newborn at home on October 10. The mother and her healthy newborn are admitted to the hospital on October 11.

Overview of Policy

No TAR is required for admission of the mother or the baby. TARs are not required for delivery or well-baby services associated with a delivery.

Mother's Claim

Enter the two-digit facility type code "11" and one-character claim frequency code "1" as "111" in the *Type of Bill* field (Box 4).

Enter the date of the mother's admission, October 11, 2015, in six-digit format (101115) in the *Admission Date* field (Box 12). Enter the 5 a.m. hour of admission in military terms (5) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "4" indicates a newborn. In the *Source of Admission* field (Box 15) enter a "4," which is required for extramural births.

The total length of the mother's stay is entered in the *Statement Covers Period* field (Box 6). Enter the day of admission (101115) as the "From" date and the day of discharge as the "Through" date. In this case, the discharge date is October 13 (101315). Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 11 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the mother was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 thru 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 159 is entered in the *Revenue Code* field (Box 42) to bill services for the mother. Enter the description of code 159 (room and board, ward) in the *Description* field (Box 43). Enter a "2" in the *Service Units* field (Box 46) to indicate the number of days the mother stayed in the hospital. Do not count the day of discharge.

All ancillary services are listed. Units of service are not required for ancillary services.

Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Enter an appropriate primary ICD-10-CM diagnosis code in Box 67. In this case, ICD-10-CM diagnosis code O70.1 indicates second degree perineal laceration. Code Z37.0 is entered as the secondary diagnosis code and indicates birth of a single live newborn. These codes are entered on the claim as O701 and Z370, respectively.

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable diagnosis codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, the perineal laceration (code O70.1) was present on admission and requires a "Y" (yes) POA. Diagnosis code Z37.0 is exempt from POA reporting requirements.

ICD-10-PCS code 10D07Z8 (extraction of products of conception, other) is an acceptable code to be entered in the *Principal Procedure* field (Box 74). Additionally ICD-10-PCS code 0UQG0ZZ (repair, vagina, open) is entered. The dates of the procedures, October 11, 2015, are entered as 101115.

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

The date of birth is included in the *Remarks* field (Box 80).

Enter the attending physician's NPI in the *Attending* field (Box 76).
Enter the operating physician's NPI in the *Operating* field (Box 77).
Enter the admitting physician's NPI in the first *Other* field (Box 78).

Newborn's Claim

Enter the two-digit facility type code "11" and one-character claim frequency code "1" as "111" in the *Type of Bill* field (Box 4).

Enter the date of the baby's admission, October 11, 2015, in six-digit format (101115) in the *Admission Date* field (Box 12). Enter the 5 a.m. hour of admission in military terms (5) in the *Admission Hour* field (Box 13). In the *Admission Type* field (Box 14) enter the "type" of admission. In this case, the "4" indicates a newborn. In the *Source of Admission* field (Box 15) enter a "4" to indicate an extramural birth.

The total length of the baby's stay is entered in the *Statement Covers Period* field (Box 6). Enter the day of admission (101115) as the "From" date and the day of discharge as the "Through" date. In this case, the discharge date is October 13 (101315). Enter the hour of discharge in military time in the *Discharge Hour* field (Box 16). In this case, the discharge hour is 11 a.m. Enter the type of discharge (to home, transferred, etc.) in the *Status* field (Box 17). In this case, the "01" indicates the baby was "discharged to home."

The patient's Medicare status is shown in the *Condition Codes* field (Boxes 18 thru 28). Condition code "YO" indicates the recipient is under age 65 and does not have Medicare coverage.

Revenue code 171 is entered in the *Revenue Code* field (Box 42) to bill services for the well baby. Enter the description of code 171 (nursery newborn, Level I) in the *Description* field (Box 43). Enter a "2" in the *Service Units* field (Box 46) to indicate the number of days the baby stayed in the hospital. Do not count the day of discharge.

All ancillary services are listed. Units of service are not required for ancillary services.

Enter the usual and customary charges in the *Total Charges* field (Box 47). Enter code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in "TOTALS" (Box 47, line 23).

Enter an appropriate primary ICD-10-CM diagnosis code in Box 67. In this case, ICD-10-CM diagnosis code Z38.1 represents a single liveborn baby born before admission to the hospital. ICD-10-CM diagnosis code Z3A.37 represents gestational age of pregnancy of 37 weeks. The codes are entered on the claim as Z381 and Z3A37.

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable diagnosis codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate Z38.0 thru Z38.8 code for the birth episode.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, diagnosis code Z38.1 is exempt from POA reporting requirements. Diagnosis code Z3A.37 requires a "Y" (yes) POA.

No procedures were performed on the baby so the *Principal Procedure* field (Box 74) is left blank.

Note: Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

The date of birth is included in the *Remarks* field (Box 80).

Enter the attending physician's NPI in the *Attending* field (Box 76).
Enter the operating physician's NPI in the *Operating* field (Box 77).
Enter the admitting physician's NPI in the first *Other* field (Box 78).

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL #

b. MED. REC. #

4 TYPE OF BILL: 111

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM: 101115 THROUGH: 101315

7

8 PATIENT NAME a

b DOE, JANE

9 PATIENT ADDRESS a b c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 CONDITION CODES
12241990	F	101115	5	4		11	01	YO

CONDITION CODES 19 20 21 22 23 24 25 26 27 28 · 29 ACDT STATE · 30

31–34 OCCURRENCE CODE/DATE · 35–36 OCCURRENCE SPAN CODE/FROM/THROUGH · 37

38

39–41 VALUE CODES CODE/AMOUNT a 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
159	ROOM & BOARD, WARD			2	400000		
250	GENERAL PHARMACY				11025		
300	GENERAL LABORATORY				43900		
720	LABOR ROOM/DELIVERY GEN.				64000		
710	RECOVERY ROOM GENERAL				43500		
001	*PAGE ____ OF ____*	*CREATION DATE*		***TOTALS***	562425		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789
I/P MEDI-CAL					562425	57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		90000000A95001		

63 TREATMENT AUTHORIZATION CODES · 64 DOCUMENT CONTROL NUMBER · 65 EMPLOYER NAME

66 DX: 0 · 67: O701 Y · A: Z370

68

69 ADMIT DX · 70 PATIENT REASON DX · 71 PPS CODE · 72 ECI · 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE
10D07Z8	101115	0UQG0ZZ	101115		

c. d. e. OTHER PROCEDURE CODE DATE

75

76 ATTENDING NPI 1234567890 QUAL · LAST · FIRST

77 OPERATING NPI 2345678901 QUAL · LAST · FIRST

78 OTHER NPI 3456789012 QUAL · LAST · FIRST

79 OTHER NPI QUAL · LAST · FIRST

80 REMARKS
DELIVERY DATE 101015

81CC a b c d

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Figure 3a: Vaginal Delivery Prior to Hospital Admission.
Mother's Claim. DRG-Reimbursed Hospital.

Page updated: September 2020

Field	Entry
1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555
2	
3a PAT. CNTL #	
b. MED. REC. #	
4 TYPE OF BILL	111
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM	101115
6 STATEMENT COVERS PERIOD THROUGH	101315
7	
8 PATIENT NAME	b DOE, BABY
9 PATIENT ADDRESS	
10 BIRTHDATE	10102015
11 SEX	F
ADMISSION 12 DATE	101115
13 HR	5
14 TYPE	4
15 SRC	4
16 DHR	11
17 STAT	01
CONDITION CODES 18	YO
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39–41 VALUE CODES CODE / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
171	NURSERY NEWBORN, LEVEL I			2	60000		
300	GENERAL LABORATORY				20300		
001	PAGE ____ OF ____	CREATION DATE		TOTALS	80300		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A I/P MEDI-CAL					80300	0123456789

57 OTHER PRV ID:

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A JANE DOE	03	90000000A95001		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

Field	Entry
66 DX	0
67	Z381
A	Z3A37 Y
68	
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	1234567890
77 OPERATING NPI	2345678901
78 OTHER NPI	3456789012
79 OTHER NPI	
80 REMARKS	DATE OF BIRTH 101015
81CC	

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Figure 3b: Vaginal Delivery Prior to Hospital Admission.
Newborn's Claim. DRG-Reimbursed Hospital.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.