UB-04 Tips for Billing: Long Term Care Services

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This section describes *UB-04* claim fields that must be completed accurately and completely in order to avoid claim suspense or denial. Tips below are designed to supplement instructions in the *UB-04 Completion: Long Term Care Services* section of this manual.

Common Billing Errors Table

Field	Description	Error
Remarks	Medicare Part B, duplicate claim	Billing two Part B Medicare claim lines for the same recipient with overlapping dates of service. **Billing Tip:** Enter the reason for the overlapping dates of service in the *Remarks* field. For example, "Line 1: This is not a duplicate claim. This claim is for speech therapy. Line 2: The physical therapy claim (same recipient for overlapping dates of service) was billed on an earlier date [give specific date]. A copy of the claim is attached."
Remarks	Share of Cost (SOC)	Failure to identify the reason for reduction in a recipient's Share of Cost (SOC). **Billing Tip:** Identify the SOC for the patient minus the non-covered services in the *Remarks* field. For example, "Share of Cost 300.00 minus non-covered services 27.70 equals Patient Liability/Medicare Deductible 272.30."
Unlabeled (Box 37a)	Billing Limit Exceptions	Omitting valid delay reason codes for claims submitted more than six months from the date of service. **Billing Tip:** Enter the delay reason code in the designated field.

Common Billing Errors Table (continued)

Field	Description	Error
Status	Patient Status	Entering the patient status code in the wrong field. **Billing Tip:** Enter the status code in the *Status* field.
Prior Payments	Other Health Coverage (OHC)	Claim submitted to Medi-Cal with a billing limit exception code or delay reason code or attachment indicating that the claim was submitted to Medicare and/or Other Health Coverage (OHC) more than one year from the month of service. **Billing Tip:** Bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements. Submit claim to the California MMIS Fiscal Intermediary within 60 days of Medicare or OHC carrier's resolution. Use the OHC *Explanation of Benefits* date or Medicare Remittance Advice date to calculate timeliness.
Statement Covers Period From/Through	Date of Service (From – Through)	From – through dates of service do not correspond with the authorized from – through dates of service on the *Treatment Authorization Request* (TAR). **Billing Tip:** Verify that the dates of service on the claim match the approved dates on the TAR, or obtain a revised TAR.

Field Completion Reminders

Providers should remember the following when completing the claim form.

- If an error has been made for a particular recipient, enter an "X" in the *Unlabeled* field (Box 49) to delete both the upper and lower lines. The information on both lines will be "ignored" by the system and will not be entered as a claim line. Enter the correct billing information on any other line.
- Enter the 11-digit TAR Control Number in the *Treatment Authorization Codes* field (Box 63a thru c).
- Enter dates of service in a six-digit format for Month, Day, Year (MMDDYY). For example, if the date of service is July 12, 2002, enter as 071202 in the *Statement Covers Period From/Through* field (Box 6).

Bed Hold Reminders

To prevent claim denials because the service(s) on the claim is a duplicate of a previously paid claim, providers should remember the following:

- Check regularly for recipients on leave at home, at an acute hospital or transferred to another LTC facility.

  Note: If the patient has changed to another facility, be sure to bill with the appropriate patient status code. For additional patient status code information, refer to the *UB-04 Completion: Long Term Care Services* section of this manual.
- Verify that dates of service on the claim reflects only the dates for services rendered.
- Verify that the facility to which the recipient was transferred is billed correctly.

If another facility erroneously submitted a claim and received payment for the same recipient and same date of service but has not resubmitted a corrected claim, providers are advised to submit an inquiry to the Correspondence Specialist Unit for research. Refer to the *Provider Relations Directory* in the Part 1 manual for the mailing address.

Paper Claim Form Requirements

The following paper claim form requirements and standard billing procedures can speed claim processing and prevent delays. Before submitting claims, check to see that:

- The original claim is submitted. Carbon copies or photocopies, computer-generated claim form facsimiles or claim forms created on laser printers are not acceptable.

  Individual claim forms are separated. Each claim is processed separately. Do not staple original claims together. Stapling original claims together indicates the second claim is an "attachment," not an original claim to be processed separately.

- All perforated sides are removed. For accurate scanning, be sure to leave a ¼-inch border on the left and right side of the form after removing the perforated sides.

- Information is typed within the designated area of the field. Be sure the type falls completely within the text space and is properly aligned with corresponding information. If using a DOT matrix printer, do not use "draft mode." The characters do not have enough distinction and clarity for the optical character reader to accurately determine the contents.

- All dates are entered without slashes. Do not use punctuation, such as decimal point (.), dollar sign ($), positive (+) or negative (-) symbol when entering amounts.

- Attachments are taped to an 8½ x 11-inch sheet of paper with non-glare tape. Do not use original claims as attachments.

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.