Facility Billing Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Value & Balance Exchange reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Value & Balance Exchange's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Value & Balance Exchange may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Value & Balance Exchange enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Value & Balance Exchange due to programming or other constraints; however, UnitedHealthcare Value & Balance Exchange strives to minimize these variations.

UnitedHealthcare Value & Balance Exchange may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to UnitedHealthcare Value & Balance Exchange products.

This reimbursement policy applies to services reported using the UB-04 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities, including but not limited to, non-network authorized and percent of charge contract facilities.

Policy

Overview

The uniform bill known as the UB-04, also called the CMS-1450, is used by Medicare and many major third-party payers for billing facility services.

The data elements and design of the billing formats are determined by the National Uniform Billing Committee (NUBC) at the request of CMS, the state uniform billing committees (SUBC) and provider and payer associations. Most of the UB-04 Form Locators (FLs) are required data elements for Medicare billing. Unassigned codes and spaces on the claim form are available to meet the future reporting needs of CMS and state and local regulatory agencies and payer-specific requirements for hospital billing. The form and EDI format are flexible to accommodate most third-party payers and hospitals and to promote uniform use of the claim. The FL requirements, revenue codes and subcategory codes are revised on an ongoing basis by the NUBC.

Reimbursement Guidelines

This policy addresses Form Locators (FLs) on the UB-04 and the required information for each field. If the information submitted is missing, incomplete, or invalid, the claim will be denied.

Fields included in this policy include, but are not limited to:

- Bill Type
- Discharge Status
- Principal diagnosis
- Source of Admission
- Condition code
- Type of Admission
- Patient age
- Patient gender

Other information that is required and will cause claim denials if incorrect includes, but is not limited to:

- Age to procedure &/or diagnosis conflict
- Gender to procedure &/or diagnosis conflict
- Procedure &/or diagnosis code requires additional digit(s)
- Use of E code as a primary diagnosis
- Services provided after the discharge date range

Questions and Answers

1	**Q:** What is the source of these Facility Edits? **A**: Some of these edits are sourced to the CMS Medical Code Edits (MCE). Please see the CMS website (www.cms.gov) for further information on the content of these edits. Others are sourced to NUBC.
2	**Q**: What types of scenarios are addressed in these Facility Edits? **A**: These edits are intended to ensure that facilities submit correctly coded, clean claims. They address things like diagnoses having the correct number of digits, procedures and diagnoses are appropriate for the age and/or gender of the member, the discharge status on the claim is valid, and both the Admission and Discharge dates are valid for the claim.

Resources

National Uniform Billing Committee (NUBC) CMS

Medical Code Edits (MCE) OptumInsight, Inc. *UB Editor*

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History

1/1/2021	Policy implemented by UnitedHealthcare Value & Balance Exchange