Facility Billing Policy for Louisiana

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 Community Plan reimbursement policies uses 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 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 Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.

***Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the facility 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 Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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. CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid 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.
3	Q: Aren't these Facility Edits in place already? A: There is minimal editing being done on inpatient facility claims currently. UnitedHealthcare Community Plan does have robust editing in place on professional claims, and some editing on outpatient facility claims. We will now be holding the facilities to the same level of clean claim submission standards that are professional providers are held to. These are edits that CMS has had in place for Medicare FFS claims for several years.
4	Q: Why is UnitedHealthcare Community Plan choosing to implement these Facility Edits? A: There are many reasons for implementing these edits. Facilities should be expected to submit appropriately coded, clean claims. UnitedHealthcare Community Plan, as a Managed Care Organization, need to be good stewards of the money entrusted to us by the States we serve, by only paying those claims that are submitted appropriately. Right now, without these edits, we likely are paying claims that we should not be, as many of the scenarios in these edits are not being caught currently. As facilities become better educated (and perhaps more cautious) on how to appropriately submit their claims to us, we will eliminate inappropriately paid claims and facilities will improve their coding and billing practices.
5	Q: What should a facility do if a claim is denied based on one of these edits? A: The facility should submit a corrected claim, as appropriate, where the item in question is corrected, following the usual corrected claim process.

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

2/25/2020	Title section: Removed Annual Approval information & moved policy # to the header History section: Entries prior to 2/25/2020 archived
9/1/2012	Policy Posted by UnitedHealthcare Community & State