

Hospital Billing Scenarios

The billing examples herein are of various types of hospital services that may be submitted to the Department. Particular form locators affected and instructions for completion are identified with each scenario.

The following billing scenarios apply only to institutional claims. Ambulatory Procedures Listing (APL) policy does allow a fee-for-service claim to be submitted under the name and NPI of one salaried physician involved in direct patient care. This fee-for service claim may be billed in addition to the outpatient institutional claim.

Billing Scenario 1 - Inpatient Medicare/Medicaid Combination Claim (“Crossover”)

The patient was admitted to the hospital on June 15, 20XX and discharged on June 22, 20XX. This patient has Medicare Part A and B coverage as well as Illinois Medicaid coverage. The provider is billing for the Medicare Part A deductible.

FL 39-41 – Value Codes. Enter Value Code A1 and the Medicare deductible amount due. (In a case when the coinsurance, not deductible, is due, enter Value code A2).

FL 50, Line A – Payer Name. Enter “Medicare.” Illinois Medicaid is listed after all other payers.

FL 51, Line A – Health Plan ID. Enter “909,” the Department’s legacy three-digit TPL code for Medicare Part A; a space; and then two-digit TPL status code “01.”

FL 54, Line A – Prior Payment. Enter the net reimbursement amount from Medicare.

Billing Scenario 2 - Inpatient Claim with Medicare Part B and Medicaid Coverage

The patient was admitted as an inpatient on February 17, 20XX. On February 19th, the patient was transferred to another larger general inpatient facility. The patient has Medicare Part B only coverage, as well as Illinois Medicaid coverage.

FL 4 – Type of Bill. For inpatient Part B only claims, enter “0121.”

FL 22 – Discharge Status – “02” (transferred to another short term hospital.)

FL 50, Line A – Enter “Medicare.” Illinois Medicaid is listed after all other payers.

FL 51, Line A - Enter “910,” the Department’s legacy three-digit TPL code for Medicare Part B; a space; and then two-digit TPL status code “01.”

FL 54, Line A – Prior Payments. Enter the net reimbursement amount from Medicare Part B.

Billing Scenario 3 - Inpatient Claim with Third Party Liability (TPL)

The patient was admitted to the hospital on May 18, 20XX and discharged on May 21, 20XX. The patient has Blue Cross/Blue Shield insurance that paid toward her hospital stay, and also Illinois Medicaid coverage.

FL 50, Line A – Payer. Enter “Blue Cross/Blue Shield.” Illinois Medicaid is listed after all other payers.

FL 51, Line A - Enter the appropriate legacy three-digit TPL code for Blue Cross/Blue Shield; a space; and then two-digit TPL status code “01.”

FL 54, Line A – Prior Payment. Enter the actual payment received from the third party payer.

Billing Scenario 4 - Inpatient Admission with Non-Covered Days

The patient was admitted on November 12, 20XX and discharged the following January 6, 20XX. Effective January 1, the patient was not eligible for Illinois Medicaid.

FL 6 – Statement Covers Period. Enter the actual admission through discharge dates.

FL 18-28 – Condition Codes. Enter “C3.”

FL 35-36 – Occurrence Span. Line A, enter code “74” with the non-covered date span that must equal the number of non-covered days billed.

FL 39-41 – Value Codes. Enter Value Code 80 with the number of covered days (50.) Enter Value Code 81 with the number of non-covered days (5.) The date of discharge is not counted as a non-covered day.

FL 46 – Service Units. Enter units for the covered accommodation days.

FL 47 – Total Charges. List the total charges for the entire admission.

FL 48 – Non-covered Charges. Indicate charges for the non-covered days, as well as any other non-covered charges.

Billing Scenario 5 - Inpatient Transfer from General Care to Psychiatric Care

The patient was admitted on March 2, 20XX for a medical condition and was transferred to the psychiatric unit on March 7th. The patient was discharged on March 15th. Two UB-04 invoices will be required.

Medical Claim:

FL 4 – Type of bill. Enter “0111” (admission through discharge claim.)

FL 6 – Statement Covers Period. Enter the admit date through the transfer date.

FL 12 – Admission Date. Enter the actual date the patient was admitted to the hospital.

FL 17 – Patient Discharge Status. Must use discharge status “65.”

FL 67 – Principal Diagnosis Code. Enter the principal diagnosis for the medical problem.

Psychiatric Claim:

FL 4 – Type of Bill. Enter “0111” (admission through discharge claim.)

FL 6 – Statement Covers Period. Enter the date the patient transferred to psychiatric care through the discharge date.

FL 12 – Admission Date. Enter the date the patient was transferred from general care to psychiatric care.

FL 17 – Patient Discharge Status. Enter actual discharge status for the psychiatric stay.

FL 67 - Principal Diagnosis Code. Enter the principal diagnosis for the psychiatric illness.

Billing Scenario 6 - Medicare Part A Exhaust During Inpatient Stay

The patient has Medicare Part A and B. He was admitted to the hospital on March 10, 20XX and was discharged on June 24, 20XX. His Part A benefits exhausted on June 3, 20XX. Two claims will be required for this inpatient stay.

Claim 1: Medicare Claim

FL 4 – Type of Bill. Enter “0111.”

FL 6 – Statement Covers Period. This patient was eligible for Medicare Part A from 031020XX through 060320XX.

FL 39-41 – Value Codes. Enter Value Code 80 – Covered Days and the number of days (85 days). Enter Value Code A2 and the coinsurance amount due.

- FL 46** – Service Units. Enter 85 covered accommodation days.
- FL 47** – Total Charges. Enter the total charges for the 85 covered days.
- FL 50, Line A** – Payer. Medicare is the primary payer.
- FL 51, Line A** – Health Plan ID. Enter “909,” the Department’s legacy three-digit TPL code for Medicare Part A; a space; and then two-digit TPL status code “01.”
- FL 54, Line A** – Prior Payment. Enter the net reimbursement amount from Medicare.

Claim 2: Medicaid Claim

- FL 4** – Type of Bill. Enter “0121.”
- FL 6** – Statement Covers Period. Enter the actual date of admission through the discharge date (March 10, 20XX through June 24, 20XX).
- FL 18-28** - Condition Codes. Enter a “C1.”
- FL 35-36** – Occurrence Span. Line A, enter code “74” with the non-covered date span that must equal the number of non-covered days listed as Value Code 81.
- FL 39-41** – Value Codes. Enter Value Code 80 – Covered Days and the number of days under the Medicaid coverage (21 days). Enter Value Code 81 – Non-covered Days and the number of days that were covered under Medicare (85 days).
- FL 46** – Service Units. Enter the number of covered accommodation days.
- FL 47** – Total Charges. Total charges for all 106 days of care.
- FL 48** – Non-covered Charges. Enter charges for the non-covered days of care, plus any other non-covered charges.
- FL 50, Line A** – Payer. Medicare is the primary payer.
- FL 51, Line A** – Health Plan ID. Enter “910,” the Department’s legacy three-digit TPL code for Medicare Part B; a space; and then two-digit TPL status code “01.”
- FL 54, Line A** – Prior Payment. Enter the net reimbursement amount from Medicare Part B.

The Medicaid claim requires a manual override and must be submitted to the billing consultant.

Billing Scenario 7 - Late Ancillary Charges – Inpatient/Outpatient

A provider submitted a claim that was approved and paid by Illinois Medicaid. The provider then discovered ancillary charges that were omitted from the bill. This claim will be submitted to identify the undercharge from the original claim.

- FL 4** – Type of Bill. The frequency digit (fourth digit) must be a “5.”
- FL 6** – Statement Covers Period. Enter the date or dates of service from the original paid claim.
- FL 42** – Revenue Codes. Enter the revenue code that identifies the missing ancillary service.
- FL 47** – Total Charges. Enter the charges missing from the original claim.

A late ancillary claim does not affect a previously paid claim. If the omitted charges would have affected the payment, the claim must be voided and resubmitted and include all charges.

Billing Scenario 8 - Inpatient Claim Selected for Retrospective Prepayment

The patient was admitted on July 8, 20XX and was discharged on July 14, 20XX. The claim met the criteria for selection for retrospective prepayment review. The Department’s Quality Improvement Organization (QIO) denied the days of July 12th and July 13th as not medically necessary. The QIO sent the hospital an advisory notice informing them of the denied days.

FL 39-41 - Value Codes. The claim must be coded according to the QIO Advisory Notice. In this case, enter Value Code 81 and the number of non-covered days.

FL 35-36 – Occurrence Span. Line A, enter code “74” with the non-covered date span that must equal the number of non-covered days billed.

FL 48 – Non-covered Charges. Enter charges for the non-covered days of care, plus any other non-covered charges.

The claim must be billed as a paper UB-04 with the QIO Advisory Notice attached.

Billing Scenario 9 - Inpatient Admission with Admission/Concurrent/Continued Stay Review

The patient was admitted on August 11, 20XX with a medical diagnosis requiring utilization review. The diagnosis code requires the hospital to contact the Department’s QIO to certify the admission and assign a length of stay. (Note: If this claim is reimbursed through the DRG reimbursement system, no length of stay will be assigned). The QIO approved the admission and a length of stay through August 16th (6 days).

FL 6 - Statement Covers Period - Enter the actual admission through discharge dates. If the patient’s length of stay went beyond the date approved by the QIO, those days must be shown as non-covered.

FL 69 - Admitting Diagnosis Code – Enter the ICD-10 diagnosis code describing the patient’s diagnosis at the time of admission. Any extension of a root code, approved as the admitting diagnosis code at the time of the certification of admission, will be acceptable on the claim submitted to the Department.

Billing Scenario 10 - Outpatient Medicare/Medicaid Combination Claim (“Crossover”)

The patient has both Medicare and Medicaid coverage. She was treated at the hospital emergency room on February 8, 20XX and released.

FL 39 – 41 – Value Codes. Enter Value Code “A1” and the amount of the Medicare deductible due. (In a case when the coinsurance, not deductible, is due, enter Value Code A2).

FL 42 – Revenue Code. Enter all appropriate revenue codes.

FL 50, Line A – Payer Name. Enter “Medicare.” Illinois Medicaid is listed after all other payers.

FL 51, Line A – Health Plan ID. Enter “910,” the Department’s legacy three-digit TPL code for Medicare Part A; a space; and then two-digit TPL Status Code “01.”

FL 54, Line A – Prior Payment. Enter the net reimbursement amount from Medicare.

Billing Scenario 11 - Outpatient Same Day Surgery with Spenddown

The patient received outpatient laser surgery of the eye at a local hospital on September 2, 20XX. The procedure is listed in the Ambulatory Procedures Listing (APL). No problems arose and the patient was released the same date. Total charges on the hospital claim were \$3,582.00. The patient has a \$276.00 Spenddown to meet monthly. The hospital’s bill was used to meet the Spenddown.

FL 39-41 – Value Codes. Enter Value Code 66 and the Patient Liability Amount (\$276.00) identified on the HFS 2432, Split Billing Transmittal.

FL 42 – Revenue Code. When a surgical procedure is used on a claim, Revenue Code 0360 must be identified.

FL 44 – HCPCS/Rate. Use the appropriate APL code to identify the procedure.

A claim that identifies Spenddown must be billed on the UB-04 paper claim format with the HFS 2432 Split Billing Transmittal attached. See Topic H-260.2.3 for additional information regarding **Spenddown**.

Billing Scenario 12 - Emergency Department with Observation and Hospital Admission

The patient presented to the emergency room with chest pains on April 6, 20XX at 5:00 A.M. After examination, he was admitted to observation at 7:00 A.M. At 3:30 P.M., he was admitted as an inpatient.

Two claims may be submitted:

1st claim – Outpatient Claim

The claim will reflect the emergency room charge or the observation room charge only. All ancillaries are to be reported on the inpatient claim.

2nd claim – Inpatient Claim

The claim will be for the inpatient admission and all ancillaries that were provided in the outpatient setting prior to admission.

Under APL policy, the services of one salaried physician may be billed fee-for service in addition to the outpatient institutional APL claim. The salaried physician claim must be billed under the name and NPI of the physician who rendered the service.

If a patient is on a Spenddown case, please refer to Topic H-260.2.3 for information relating to the inpatient, outpatient, and fee-for-service charges to be submitted to the Family Community Resource Center (FCRC).

Billing Scenario 13 - National Drug Codes (NDCs) for Outpatient Series Renal Dialysis Claim

The patient is a continuing renal dialysis patient and receives treatment at a freestanding dialysis facility. This claim is for service dates beginning July 2, 20XX through July 30, 20XX, for a total of 13 dialysis treatments. The patient received Epogen (>10, 000 units) and Iron Dextran during this period of treatment.

FL 4 – Type of Bill. The first digit in this form locator must be a “0.” The second digit must be a “7.” The third digit must be a “2.” The fourth digit must be a “3,” to identify it as an interim continuing claim.

FL 6 – Statement Covers Period. The From Date is “0702XX” and the Through Date is “0730XX.” Do not automatically bill for the entire calendar month, if the patient’s beginning and ending treatment dates are not the first and last dates of that calendar month.

FL 39-41 – Value Codes. Enter Value Code 68 to report Epogen. Enter Value Code 80 with the number of covered days. This patient has 13 covered days.

FL 42 – Revenue Code. Identify the appropriate revenue code for the type of dialysis utilized. Enter revenue line “0635” to denote Epogen >10,000 units. Enter revenue line “0636” to denote Iron Dextran.

FL 43 – Revenue Description. Report the following for both revenue line 0635 (for Epogen) and 0636 (for Iron Dextran):

- Report the N4 qualifier in the first two (2) positions, left- justified
- Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens)
- Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:
 - F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Unit
- Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
- Any spaces unused for the quantity are left blank.

Form Locator 44 – HCPCS/Rates. Enter the corresponding HCPCS code associated with revenue lines 0635 and 0636. See the [Renal Dialysis Injectable Drug Listing](#).

Form Locator 46 – Service Units. For a series claim, an entry is required to correspond to the renal dialysis revenue code. In this case, enter “13.” For revenue code 0636 for Iron Dextran, enter the number of units administered.

Billing Scenario 14 - Change from Inpatient Admission to Outpatient Observation Using Condition Code 44 - Inpatient Admission Changed to Outpatient

The patient was admitted with an inpatient order on January 1, 20XX. On January 2nd, the hospital determined that the inpatient admission was not medically necessary and the patient could have been placed in observation. A new order was written beginning January 2nd for outpatient services that included observation. The patient was discharged from observation on January 3rd and returned home.

FL 6 - The hospital may submit an outpatient claim identifying FL 6 Statement Covers Period as January 1st through January 3rd.

FL 28 – Condition Code 44 must be utilized in FL 18-28.

Ancillary services provided from January 1st through January 3rd should be identified. Observation service dates should reflect January 2nd and January 3rd. No accommodation revenue codes should be placed on this outpatient claim.

As there was at least one Ambulatory Procedures Listing (APL) service on the claim (observation) beginning January 2nd, the claim will process through the Enhanced Ambulatory Patient Groups (EAPG) grouper. Claims billed with Condition Code 44 that do not contain at least one APL service will pay at zero and cannot be billed as fee-for-service under the hospital’s fee-for-service NPI.

Hospitals are reminded that if an inpatient claim is billed and the Department's Quality Improvement Organization denies that stay as not medically necessary, the hospital may not submit **any** claim for the stay.