Hospital Providers

Patient Status, Occurrence, Condition, and Admission Type Codes

Effective with dates of service on and after April 7, 2006, patient status, occurrence, condition, and admission type codes were updated to reflect Medicare's approved lists.

Condition codes 81, A7, A8, X0, and Z1 are no longer covered. The codes that replaced them are as follows:
- AI (sterilization) replaced 81
- AA (abortion performed due to rape) replaced A7
- AB (abortion performed due to incest) replaced A8
- D9 (any other change) replaced the XO swing bed condition code
- 67 (beneficiary elects not to use lifetime reserve (LTR) days) replaced the Z1 Medicare Part A benefits exhausted condition code
  - The verbiage in the explanation of condition code 67 means the patient's benefits are exhausted.

Occurrence code 50 is no longer covered. This code will not be replaced and is no longer required to be used by providers.

Updated manual pages for this bulletin are attached.

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, select the *Hospital Provider Manual*, pages 7-2 through 7-7, 7-14, and 7-21 through 7-26.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or 785-274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

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EDS is the fiscal agent and administrator of the Kansas Medical Assistance Program for the Division of Health Policy and Finance.

FL 6 **Statement Covers Period - From/Through - Required**. Enter inpatient dates of admission and discharge or outpatient from and through dates in MM/DD/YY format.

FL 7 **Covered Days - Required - Inpatient Only**. Enter the number of days for which you are billing. **NOTE:** Count date of admission, but not date of discharge.

FL 8 **Non-Covered Days - Required** - Enter the total number of non-covered days.

FL 12 **Patient Name - Required** - Enter patient's last name, first name and middle initial exactly as it appears on the ID card. If patient is a newborn, enter "newborn", "baby boy", or "baby girl" in the first name field and enter the last name.

FL 14 **Birthdate - Required**. Enter patient's date of birth in MM/DD/YYYY format. If newborn, enter baby's date of birth (not mother's).

FL 15 **Sex - Required**. Enter "M" for male or "F" for female. If newborn services, enter "M" or "F" for the baby.

FL 17 **Admission Date - Required**. Enter date patient was admitted as inpatient **or** date of outpatient care in MM/DD/YY format.

FL 18 **Admission Hour - Required - Inpatient Only**. Enter treatment hour using the continental time system (i.e., 6:00 p.m. = 1800 hours).

FL 19 **Admission Type - Required - Inpatient Only**. Enter a one-digit code to indicate type of admission.
  1 – Emergency   3 – Elective
  2 – Urgent, etc.   4 – Newborn
  5 – Trauma

FL 20 **Admission Source - Required** - Enter a one digit code to indicate admission source.
  4 - Transfer from Hospital
  5 - Transfer from Nursing Home
  6 - Transfer from Another Facility

7000. Updated 5/06

FL 22   **Patient Status - Required - Inpatient Only**. Enter a two-digit code to indicate status of patient:

01   Discharged to home or self care (routine discharge)

02   Discharged/transferred to another short-term general hospital for inpatient care

03   Discharged/transferred to skilled nursing facility (SNF) with Medicare certification ~~(For hospitals with an approved swing bed arrangement, use Code 61 Swing Bed. For reporting discharges/transfers to a non-certified SNF, use Code 04 ICF.)~~

04   Discharged/transferred to an Intermediate Care Facility (ICF)

05   Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care. ~~to another type of institution (including distinct parts). Transfers from acute care institutions to Children's Hospital.~~

06   Discharged/transferred to a home under care of organized home health service organization

07   Left against medical advice or discontinued care

08   Discharged/transferred to home under care of a home IV drug therapy provider. This is not a certified Medicare provider.

09   Admitted as an inpatient to this hospital (for use on Medicare Outpatient Hospital claims only)

20   Expired (or did not recover - Christian Science Patient)

30   Still patient

40   Expired at home (Hospice claims only)

41   Expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice (Hospice claims only)

42   Expired - place unknown (Hospice claims only)

43   Discharge/transferred to a Federal Health Care Facility

50   Discharge to hospice - home

51   Discharge to hospice - medical facility

61   Discharged/transferred ~~within this institution~~ to a hospital based, Medicare approved, swing bed

62   Discharged/transferred to ~~another rehabilitation facility~~ an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

63   Discharged/transferred to a Medicare certified long term care hospital (LTCH)

64   Discharge/transferred to a nursing facility certified under Medicaid but not certified under Medicare

65   Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (for future use). Providers shall continue to use Patient Status Code 05 until further notice

66   Discharged/transferred to a Critical Access Hospital (CAH) for discharge dates on or after January 1, 2006

71   ~~Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care~~

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72   Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care

Note: Hospitals will be eligible for full DRG reimbursement when a discharge occurs using discharge code 01, 03, 04, 05, 06, 07, 08, 20, 50, or 51. Distinct claim forms must be submitted for each discharge. In the case of transfers to same specialty providers (discharge code 02), the transferring hospital's reimbursement may be reduced, based upon a transfer prorated reimbursement determination, and the receiving hospital will be eligible to receive a full DRG reimbursement.

FL 23   **Medical Record No.-Desired.** Enter the patient's medical record number. (This number will appear on the provider's Remittance Advice.)

FL 24-30   **Condition Codes** - Enter one of these two-digit codes to indicate a condition(s) relating to inpatient or outpatient claims, special programs or procedures (e.g., KAN Be Healthy, sterilization, etc.)

Note: This is not a complete list. For a complete list of Condition Codes contact EDS Customer Service.

01 Military service related
02 Condition is employment related
03 Patient covered by insurance not reflected here
67* Beneficiary elects not to use life time reserve (LTR) days
     *This will now replace the Z1 Medicare Part A benefits exhausted condition code. The verbiage in the explanation of condition code 67 means the patient's benefits are exhausted.
80 Sterilization Home Dialysis – Nursing Facility
81 Hysterectomy
A1 KAN Be Healthy (EPSDT)
A4 Family Planning
AA Abortion performed due to rape
AB Abortion performed due to incest
AI Sterilization
D9* Any other change
     *This will now replace the XO swing bed condition code
A7 Abortion – danger to life
A8 Abortion – rape/incest
X0 Swing bed
Z1 Medicare Part A benefits exhausted

FL 32-35   **Occurrence Codes/Dates: OCCURRENCE CODES CAN ONLY BE SUBMITTED ON LINE A.**
The following occurrence codes **must** be indicated if reporting information on type of accident, crime victim, other insurance denial or date of TPR

termination, or aborted surgery, false labor or non-delivery claim where associated services are indicated.

Note: This is not a complete list. For a complete list of Occurrence Codes contact EDS Customer Service.

01 Accident/medical coverage ~~Auto accident~~
02 No fault insurance involved – including auto accident/other ~~Auto accident/no fault insurance~~
03 Accident/tort liability
04 Accident/employment related
05 Accident/no medical or liability coverage ~~Other accident~~
06 Crime victim
24 Date insurance denied
25 Date benefits terminated by primary payer
~~50 Aborted surgery/False labor/Patient did not deliver~~
A3 Benefits exhausted, Payer A
B3 Benefits exhausted, Payer B
C3 Benefits exhausted, Payer C

All EDS/SRS guidelines remain the same regarding attachments required for TPR proof and SSA/Medicare EOMBs.

FL 42 **Rev. Cd. - Required - Inpatient Only.** Enter the three-digit number identifying the type of accommodation and ancillary service(s). **DO NOT INDICATE REVENUE CODE(S) IF THE SERVICE IS NON-COVERED.** NOTE: Revenue codes are not to be indicated for outpatient services

FL 44 **HCPCS/Rates - Required - Outpatient Only.** List the **HCPCS** procedure code for each specific outpatient procedure. **DO NOT INDICATE PROCEDURE(S) IF THE SERVICE IS NON-COVERED.**

FL 45 **Serv. Date - Required - Outpatient Only** - Enter the date services were provided in MM/DD/YY format.

FL 46 **Serv. Units - Required.** Enter number of days for each accommodation revenue code, or appropriate units for each outpatient service billed.

FL 47 **Total Charges - Required.** Enter total charges for each coded line item. List each outpatient procedure with a specific (itemized) charge. **DO NOT INDICATE CHARGES FOR NON-COVERED SERVICES.**

Enter the total claim charge on the last line of this detail section with a revenue code of 001 in FL 42, and total charges in FL 47.

FL 48 **Non-Covered Charges - Optional** - Enter non-covered charges.

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FL 50   **Payer - Required.** Indicate all third party resources (TPR). If TPR does exist, it must be billed first. Lines B and C should indicate secondary and tertiary coverage. Medicaid will be either the secondary or tertiary coverage and the last payer. When B and C are completed, the remainder of this line must be completed as well as FL 58-62. Medicare needs to always be the last entry.

FL 51   **Provider No. - Required**. Enter your 10-digit Medicaid provider number.

FL 54   **Prior Payments - Required if other insurance is involved.** Enter amount paid by other insurance. Medicare needs to always be the last entry. (Do not

enter spenddown or copayment amounts. These reductions will be made automatically during claim processing.)

FL 57   **If this is a resubmission of a claim, enter the previous ICN.**

FL 60   **Cert. - SSN/HIC - ID No. - Required.** Enter the 11-digit beneficiary number from patient's medical ID card on line C. If newborn services, use mother's beneficiary number if newborn's ID number is unknown.

        FL 61-62   **Group Name/Insurance Group No. - Required if Medicaid is not primary payer.** Enter the primary insurance information on line A and Medicare on line C.

FL 63   **Treatment Authorization Codes -** Leave blank. (This number, if applicable, is system generated.)

FL 67   **Prin. Diag. Cd. - Required.** Enter the ICD-9-CM code indicating the primary diagnosis.

FL 68-75   **Code - Required if applicable.** Enter the ICD-9-CM code to indicate additional diagnoses.

FL 80   **Principal Procedure - Required - Inpatient/Outpatient, if applicable.** Enter the ICD-9-CM procedure code for the primary procedure and date of service. **DO NOT INDICATE THE PROCEDURE IF THE SERVICE IS NON-COVERED.**

FL 81   **Other Procedure - Required - Inpatient/Outpatient, if applicable.** Enter other procedures performed, using ICD-9-CM procedure codes and date of service. **DO NOT INDICATE THE PROCEDURE IF THE SERVICE IS NON-COVERED.**

7000. Updated 5/06

FL 82a   **Attending Phys. ID - Required -** On line a, enter the <u>attending</u> physician's Medicaid provider number. **DO NOT ENTER A GROUP PROVIDER NUMBER.**

FL 82b   **Attending Phys. Name - Desired** - On line b, the attending physician's name must be entered as last name and then first name.

FL 83A   **Other Phys. ID - Required if applicable**.
a.   Enter performing physician's Medicaid provider number.
b.   Enter performing physician's Medicaid provider name.

FL 83B   **Other Phys. ID - Required if applicable.**
a.   Enter referring physician's Medicaid provider number.
b.   Enter referring physician's Medicaid provider name.

NOTE: If the claim is for a sterilization the surgeon performing the sterilization procedure must be identified by their Medicaid provider number in field 83A(a).

FL 84   **Remarks** - Specify additional information as necessary.

FL 85   **Provider Representative - Required.** Provider Signature.
Read statement on back of claim form, sign and date.
_   Phrase "signature on file" is acceptable.
_   Provider's name typed/stamped is acceptable.

FL 86   **Date - Desired.** Date of provider representative signature.

<u>**Submission of Claim:**</u>
Send completed claim to:

> Kansas Medical Assistance Program
> Office of the Fiscal Agent
> P.O. Box 3571
> Topeka, Kansas 66601-3571

2)   Notify the local SRS Income Maintenance (IM) Worker immediately when an SRS consumer is placed in a swing bed NF. Notification shall be performed by completing parts I and II of the MS-2126. (Refer to Section 7010.) Once the IM Worker has received the MS-2126, the consumer's case will be budgeted for long-term care. The hospital will then be notified via a "Notice of Action" as to the consumer's liability to the hospital while in the swing bed NF. Providers must bill the full amount and patient liability will be deducted during processing. When billing for a Swing bed, a separate claims must be submitted for each calendar month.

Do not attach a copy of either the MS-2126 or Notice of Action to your claim form.

3)   Bill all NF days for eligible Medicare patients to Medicare first. Medicaid can be billed for any remaining amounts using the inpatient Medicare claim crossover method. (Refer to Section 3200.) If Medicare will not pay for the NF days, a copy of either the Medicare Report of Eligibility (ROE) or a Medicare denial must be attached to the Medicaid billing supporting non-payment by Medicare.

4)   Before a transfer to a swing bed NF occurs, the patient must be discharged from the inpatient unit. Use the appropriate 3-digit type of bill code in FL 4 on the UB-92 claim form. (Refer to Section 7000.) Remember, the inpatient unit is not reimbursed for the date of discharge since the swing bed NF will be reimbursed for the date of admission.

5)   The appropriate accommodation revenue code applicable to the patient's level of care shall be entered in FL 42. Bill the total number of days in FL 46 (units). In FL 47, place the total charge of days billed.

Ancillary charges: Cannot be billed on the swing bed NF claim. Any ancillary services received by the patient while in a swing bed NF, must be billed on a UB-92 claim form using the outpatient type of bill code (FL 4) and the correct HCPCS code and revenue code for the ancillary services provided. (See items 7 and 8 for supplies/services which are content of service for swing bed NF and cannot be billed separately). Indicate condition code D9 (any other change) X0 (swing bed ancillary) in FL 24-30, and enter the from and through dates of service in FL 6 on the UB-92 claim form. When multiple dates of service are being billed, enter only the first date of service in FL 45 on the UB-92 claim form.

FL 7   **Covered Days - Required - Inpatient Only**. Enter the number of days for which you are billing. **NOTE:** Count date of admission, but not date of discharge.

FL 12   **Patient Name - Required** - Enter patient's last name, first name and middle initial exactly as it appears on the ID card.

FL 14   **Birthdate - Required**. Enter patient's date of birth in MM/DD/YYYY format (i.e. October 1, 1957 would be listed as 10/01/1957).

FL 17   **Admission Date - Required**. Enter date patient was admitted to the facility in MM/DD/CCYY format.

FL 22   **Patient Status - Required - Inpatient Only**. Enter a two-digit code to indicate status of patient:

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification ~~(For hospitals with an approved swing bed arrangement, use Code 61 Swing Bed. For reporting discharges/transfers to a non-certified SNF, use Code 04 ICF.)~~
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care. ~~to another type of institution (including distinct parts). Transfers from acute care institutions to Children's Hospital.~~
06	Discharged/transferred to a home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider. This is not a certified Medicare provider.
09	Admitted as an inpatient to this hospital (for use on Medicare Outpatient Hospital claims only)
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (Hospice claims only)
41	Expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
43	Discharge/transferred to a Federal Health Care Facility
50	Discharge to hospice - home
51	Discharge to hospice - medical facility
61	Discharged/transferred ~~within this institution~~ to a hospital based, Medicare approved, swing bed

62	Discharged/transferred to ~~another rehabilitation facility~~ an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64	Discharge/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (for future use). Providers shall continue to use Patient Status Code 05 until further notice
66	Discharged/transferred to a Critical Access Hospital (CAH) for discharge dates on or after January 1, 2006
71	~~Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care~~
72	~~Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care~~

FL 23   **Medical Record No. - Desired**. Enter the patient's medical record number. (This number will appear on the provider Remittance Advice.)

FL 24-30   **Condition Codes** – **Optional**. Enter one of these two-digit codes to indicate a condition(s) relating to inpatient or outpatient claims, special programs or procedures (e.g., KAN Be Healthy, sterilization, etc.).

Note: This is not a complete list. For a complete list of Condition Codes contact EDS Customer Service.

01 Military service related
02 Condition is employment related
03 Patient covered by insurance not reflected here
67* Beneficiary elects not to use life time reserve (LTR) days
    *This will now replace the Z1 Medicare Part A benefits exhausted condition code. The verbiage in the explanation of condition code 67 means the patient's benefits are exhausted.
80 ~~Sterilization~~ Home Dialysis – Nursing Facility
81 ~~Hysterectomy~~
A1 KAN Be Healthy (EPSDT)
A4 Family Planning
AA Abortion performed due to rape
AB Abortion performed due to incest
AI Sterilization
D9* Any other change
    *This will now replace the XO swing bed condition code
A7 ~~Abortion - danger to life~~
A8 ~~Abortion - rape/incest~~
X0 ~~Swing bed~~

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7030. Updated 5/06

Z1 Medicare Part A benefits exhausted

FL 32-35   **Occurrence Codes/Dates:**   **OCCURRENCE CODES CAN ONLY BE SUBMITTED ON LINE A.**
The following occurrence codes **must** be indicated if reporting information on type of accident, crime victim, other insurance denial or date of TPR termination, or aborted surgery, false labor or nondelivery claim where associated services are indicated.

Note: This is not a complete list. For a complete list of Occurrence Codes contact EDS Customer Service.

     01   Accident/medical coverage Auto accident
     02   No fault insurance involved – including auto accident/other Auto accident/no fault insurance
     03   Accident/tort liability
     04   Accident/employment related
     05   Accident/no medical or liability coverage Other accident
     06   Crime victim
     24   Date insurance denied
     25   Date benefits terminated by primary payer
     50   Aborted surgery/False labor/Patient did not deliver
     A3   Benefits exhausted, Payer A
     B3   Benefits exhausted, Payer B
     C3   Benefits exhausted, Payer C

All EDS/SRS guidelines remain the same regarding attachments required for TPR proof and SSA/Medicare EOMBs.

FL 39   **Value Codes/Amount – Required if applicable.** Enter D3 for non-patient obligation as the value code. Enter the non-patient obligation dollar amount in the "Amount" field. Examples of non-patient obligation are Parental, Spousal, Trust.

*FL 42   **Revenue Code – Required.** Enter the three-digit code identifying the type of accommodation services. Use only the revenue codes listed below:
101 All inclusive room and board
180 NF/MH reserve days
181 Home therapeutic reserve days ICF/MH – 21 days per calendar year
183 Home leave days / Therapeutic leave days
185 Hospital leave days
189 Non-covered days

*FL 45   **Service Date – Required.** Enter first date of service for the detail line.

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*FL 46   **Service Units - Required.** Enter the total number of days for each detail line.

FL 47   **Total Charges - Required.** Enter total charges billed.

FL 50   **Payer - Required.** Enter all third party resources (TPR). If TPR does exist, it must be billed first. Lines B and C should indicate secondary and tertiary coverage. Medicaid will be either the secondary or tertiary coverage and the last payer. When B and C are completed, the remainder of this line must be completed as well as FL 58-62. Medicare needs to always be the last entry.

FL 51   **Provider No. - Required**. Enter your 10-digit Medicaid provider number

FL 54   **Prior Payments - Required if other insurance is involved.** Enter amount paid by other insurance. Medicare needs to always be the last entry. Do not enter patient liability amount. It is automatically deducted during claim processing.

FL 57   **If this is a resubmission of a claim, enter the previous ICN.**

FL 60   **Cert. - SSN/HIC - ID No. - Required.** Enter the 11-digit number from the beneficiary's medical card on line C.

FL 61-62   **Group Name/Insurance Group No. - Required if Medicaid is not primary payer.** Enter the primary insurance information on line A and Medicare on line C.

FL 67   **Prin. Diag. Cd. - Required.** Enter the ICD-9-CM code indicating the primary diagnosis.

FL 68-75   **Code - Required if applicable.** Enter the ICD-9-CM code to indicate additional diagnoses.

FL 82   **Attending Physician - Optional.**
  a. Attending physicians Kansas Medicaid provider number.
  b. Attending physicians name.

FL 84   **Remarks – Optional**. Specify additional information as necessary.

FL 85   **Provider Representative - Required.** Provider Signature.
Read statement on back of claim form, sign and date.
  _   Phrase "signature on file" is acceptable.
  _   Provider's name typed/stamped is acceptable.

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      FL 86   **Date - Desired.** Date of provider representative signature.

    *Example: Resident in home for six days with the first date of service March 1, 2005:
                Revenue code equals 180
                Field 45 equals 03/01/05
                Field 46 equals 6

<u>Submission of Claim:</u>
    Send completed claim to:

        Kansas Medical Assistance Program
        Office of the Fiscal Agent
        P.O. Box 3571
        Topeka, Kansas 66601-3571

STATE INSTITUTION FOR M/H SPECIFIC BILLING INFORMATION

Accommodation and Ancillary Charges:

> If the individual accommodation and ancillary services exceed the detail lines on the UB-92 claim form, providers may combine all similar revenue code charges together (e.g., lab, radiology) when necessary. Accommodation codes may also be 'lumped' together when necessary. This will not affect the reimbursement of the claim.
>
> State institutions may bill for ancillary services without indicating an accommodation code.

Medicare B Services:

> When Medicare B payment is made on an inpatient claim, indicate the amount paid as "Prior Payment" in FL 54 on the UB-92 claim form.

Other Insurance:

> When a consumer has other insurance, proof of payment or denial is required. Enter the amount paid by the other insurance carrier in FL 54 on the claim form. Refer to Section 3300 for specific instructions on submitting claims when other insurance is involved.

Patient/Parental Liability:

> Indicate any patient or parental liability in FL 54 on the UB-92 claim form. Payment will be deducted accordingly.

Transfers:

> When billing medically necessary incoming transfers, the following should be entered on claims for incoming transfers from other hospitals:
>
> In FL 84 "Remarks", enter "direct transfer from (hospital, city)".

Reserve Days:

> Indicate revenue code **189** in **FL 42** when billing for reserve days.