

# Uniform Billing Editor

The ultimate guide to accurate  
facility claim submissions

SAMPLE



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## ❖ FL Coding Structure

### 01 Accident/Medical Coverage

This code and corresponding date indicate an accident-related injury for which there is medical payment coverage. Provide the date of the accident or injury.

- ◆ This code identifies an injury or illness that resulted from an accident. MSP provisions apply.
- ◆ If this occurrence code is used, Medicare is not the primary payer for this claim. There can be no Medicare insurance entries on line A of FL 50 or FLs 58–62 to indicate that Medicare is primary.
- ◆ This occurrence code is valid when used with any TOB codes (FL 4) applicable to Medicare providers.
- ◆ The use of an accident code also requires that the accident hour be reported with value code 45 Accident hour, in FLs 39–41.
- ◆ The date provided with this code must not be after the through date in the statement covers period (FL 6).
- ◆ When billing clinic services (TOB code 071X in FL 4), there must be a value code 14 No-fault, including auto/other, and amount reported in FLs 39–41.
- ◆ Certain trauma diagnosis codes may identify claims for patients covered under automobile insurance, no-fault, workers' compensation, or other liability insurance for which Medicare should be the secondary payer. If the principal diagnosis code reported in FL 67 indicates trauma according to MSP development criteria, an occurrence code (e.g., 01–05) and value code 45 Accident hour (FLs 39–41), must be entered on the bill.
- ◆ This code also must be accompanied by an appropriate entry in the Value Code and Amount fields (FLs 39–41) indicating the primary payment amount when another payer is involved.
- ◆ Conditional Medicare benefits may be paid while an auto accident claim is pending payment. There must be documentation that the insurer will not pay promptly or within 120 days after receipt of the claim. The date of service for specific items and service must be treated as the claim date when determining the prompt pay period. For inpatient services, the date of discharge must be treated as the date of service when determining the prompt pay period. (*Medicare Secondary Payer Manual*, Pub. 100-05, chap. 1, secs. 10.7–10.7.2, chap. 3, secs. 30.2.1.1–30.2.2, chap. 5, secs. 40.6.1–40.6.2 [trans.107, October 24, 2014])

The following billing guidelines apply:

- Provide the appropriate occurrence codes and dates. For example, use occurrence code 24 Date insurance denied, to bill Medicare for a conditional payment when the auto accident insurer denies the claim for invalid reasons or there has been a significant delay (more than 120 days) in receiving primary payment.
- Show value code 47 Any liability insurance, with a zero dollar amount in FLs 39–41.
- On line FL 50 A Payer, indicate the primary payer responsible for ultimately paying the claim.
- In FLs 58 A–60 A, identify all information pertaining to the primary insured (i.e., the insured's name [FL 58 A], patient relationship [FL 59 A], certificate number [FL 60 A]).
- Use the Remarks field (FL 80) to explain why the conditional payment is being requested (i.e., reason why insurer denied, the attorney's name and address).

## Ancillary Services Revenue Codes (040X–049X)

### 040X # Tests Other Imaging Services

This code indicates charges for specialty imaging services of body structures.

- ◆ The APC payment for radiology includes pharmacy (except those billed under RC 0343, 0344, or 0636), anesthesia and supplies used in connection with the radiology service. Providers may bill these incident to services as part of the amount for the other imaging procedure, or bill them separately using one of the incident to radiology revenue codes for pharmacy (RC 0255), anesthesia (RC 0371) or supplies (RC 0621).
  - If billed separately, the charge must appear on the same claim as the other imaging procedure. Should the charges need to be added to a claim that has already been paid, they must be billed on an adjustment claim (TOB code 0XX7).
  - HCPCS codes are not required when billing packaged drugs, biologicals, or radiopharmaceuticals. However, CMS strongly encourages hospitals to include all appropriate HCPCS codes (FL 44) on a claim.
- ◆ Provide the number of radiology tests or services for the revenue code category 040X in the Units field (FL 46).
- ◆ Other imaging services are classified as **diagnostic services** under the preadmission provisions outlined in *Medicare Claims Processing Manual*, Pub. 100-04, chap. 3, sec. 40.3. When performed by the admitting hospital or by an entity wholly owned or operated by the hospital (or by another entity under arrangement with the hospital) within three days immediately prior to an admission to a PPS hospital the services are included in the MS-DRG payment unless there is no Part A coverage. These services must be reported on the inpatient bill.
  - An entity is considered wholly owned or operated by a hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility to be considered the sole operator, but it must have exclusive responsibility for implementing facility policies, such as conducting or overseeing a facility's routine operations.
- ◆ The dates of service on an outpatient claim for diagnostic services must not overlap the through date in the statement covers period (FL 6) or a last date of service (occurrence span code 72 First/last visit [FL 36]) that falls on the day of admission or within three days of an admission to a PPS hospital.
- ◆ According to national billing guidelines, TRICARE requires the use of a detail code, rather than the general RC 0400.
- **HCPCS codes are required** in FL 44 HCPCS/Rates, for billing other imaging services under RC 040X with TOB code (FL 4) 013X. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 3, sec. 2011)
- Hospitals may use CPT modifiers 50, 52, 59, 76, and 77, and HCPCS Level II modifiers E1–E4, FA, F1–F9, LT, RT, and TA–T9 as appropriate for radiology procedures. Modifier 52 (reduced services) may be used with a radiology procedure if there is no other CPT code available to report the reduced service. (See also appendix 4 for detailed coding tips regarding usage of this modifier.) (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 4, secs. 20.6, 20.6.4)
  - For example, if the planned procedure is a two-view chest x-ray and only one view of the chest is performed, do not report CPT code 71046-52 (for x-ray chest, two views-reduced service). Instead, report CPT code 71045 (x-ray chest, single view). If a barium swallow is not completed because the patient cannot handle the barium, report CPT code 74270-52.
  - For cases involving an interventional radiology service, modifier 52 applies only to the radiology code. Modifiers LT, RT, 73, and 74 apply to the surgical code reported. Note that Medicare considers conscious sedation to be anesthesia.

5010 refers to version 005010X223A2.

CPT/HCPCS	Revenue Code
44206 <sup>b</sup> -44208 <sup>b</sup>	0360, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519
44210 <sup>b</sup> -44212 <sup>b</sup>	0360
44213 <sup>b</sup>	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0516, 0517, 0519, 0520, 0529, 0750, 0761
44227 <sup>b</sup>	0360
44238	0360, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0520, 0529, 0761
44300 <sup>b</sup> -44310 <sup>b</sup>	0360
44312	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
44314 <sup>b</sup> -44322 <sup>b</sup>	0360
44340	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
44345 <sup>b</sup> -44346 <sup>b</sup>	0360
44360-44500	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
44602 <sup>b</sup> -44700 <sup>b</sup>	0360
44701	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
44705	0750
44715 <sup>b</sup> -44721 <sup>b</sup>	0360, 0811, 0812
44799	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
44800 <sup>b</sup> -44900 <sup>b</sup>	0360
44950-44955	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0519, 0750
44960 <sup>b</sup>	0360
44970-45108	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
45110 <sup>b</sup> -45136 <sup>b</sup>	0360
45150-45171	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750

\* This code is not covered under Medicare OPPS

- a Not to be used for OPPS billing
- b Inpatient only procedure under OPPS
- c ESRD only
- d HHA only

CPT/HCPCS	Revenue Code
45172	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0761, 0940
45190-45386	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
45388-45393	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0516, 0517, 0519, 0750
45395 <sup>b</sup> -45397 <sup>b</sup>	0360
45398-45399	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
45400 <sup>b</sup> -45402 <sup>b</sup>	0360
45499	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0516, 0517, 0519, 0520, 0529, 0750, 0761
45500-45520	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
45540 <sup>b</sup>	0360
45541	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0519, 0750
45550 <sup>b</sup>	0360
45560	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
45562 <sup>b</sup> -45825 <sup>b</sup>	0360
45900-45915	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
45990	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0516, 0517, 0519, 0520, 0529, 0750, 0761
45999-46221	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
46230-46288	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519
46320-46500	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0515, 0516, 0517, 0519, 0750
46505	0360, 0361, 0450, 0490 <sup>a</sup> , 0510, 0514, 0516, 0517, 0519, 0520, 0529, 0750, 0761

\* This code is not covered under Medicare OPPS

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- b Inpatient only procedure under OPPS
- c ESRD only
- d HHA only

### ► New or Changed Information

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