Pulse Complete EHR

UB92 and UB04 Setup Guide

Pulse™

Electronic Healthcare Management

www.pulseinc.com

About This Reference Guide

This documentation is for the continuing education of our customers using the Pulse Complete EHR software version 2011. It is not intended for use with older versions of the Pulse Complete EHR software due to the many functional and other differences between the previous versions.

The Pulse Complete EHR software is under constant development, and the reference materials are updated frequently. The most recent versions of all Pulse reference materials are always available online at http://pace.pulseinc.com/.

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1 UB92/UB04 Insurance Setup

1.1 Introduction

There are two methods to configuring the setup for producing UB92s.

- **Two Company Option – i.e. a Medical Practice and a Surgery Center:** If the practice agrees that they want to track the AR balances and Statements separately then setup two companies.
  - Setup Medical Office Company with Claim Format HCFA.
  - Setup Surgery Center Company with Claim Format UB92.
  - Setup Insurance Plan formats as UB92 for those plans that require UBs. The Company claim format will override this and the Medical Office will produce HCFAs and the Surgery Center will produce UB92s.
  - Setup Register Patient insurance policies as normal.
- **One Company Option – i.e. Rural Health Clinic:** If they have ONE company that files a HCFA or UB92 based on the facility and don't want to setup the two company option because they don't' want separate AR and Statements:
  - Setup the ONE Company as Claim Format UB92.
  - Setup a separate insurance plan for each format. Example "Medicare – Hcfa" and "Medicare – UB92" and set the Insurance Plan Format appropriately.
  - Setup the most likely plan as the PRIMARY insurance policy in register patient.
  - Setup the other plan as type "Other" and as RIDER TO the Primary insurance policy in register patient. RIDER COVERAGE plans do NOT act as supplemental insurance on the patient's record so they won't create a supplemental claim when the primary claim is closed.
  - Instruct Charge Entry to select the appropriate policy in the Insurance Name drop down list when posting to the facility.

1.2 Sitefile Setup

- **CHARGE_ENTRY**
  - **Display UB92 Info:** if checked the **REV** and **V3Prc** columns will display.

- **PERIOD CLOSE**
  - **Use NPI UB04 Form:** Check this item if the practice uses the UB04 form. Leave unchecked if the practice uses UB92 forms.

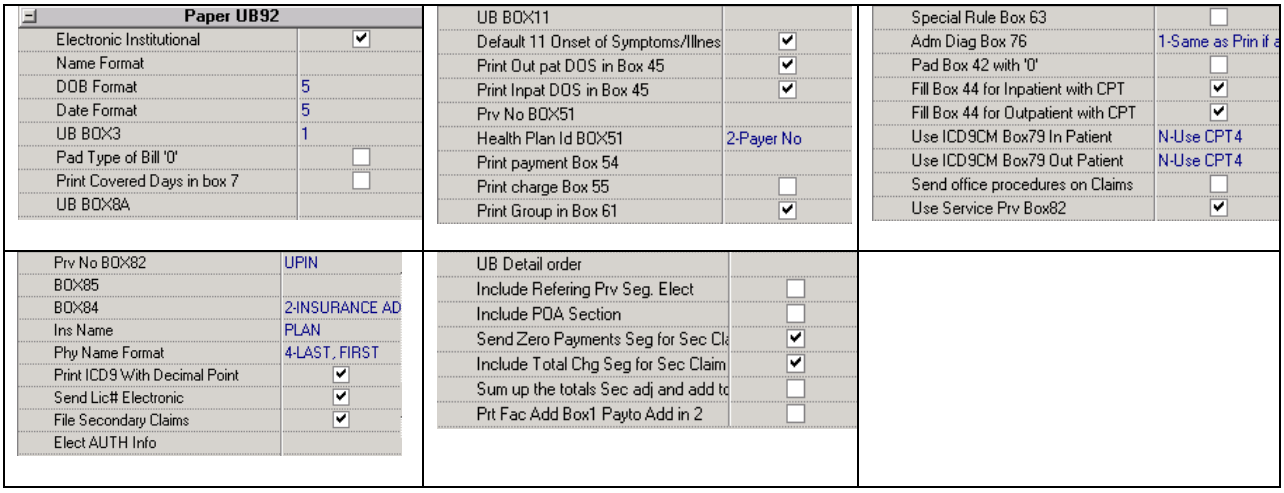
- **PROCESSING**
  - **Facility Type**: Select the appropriate value, typically SAME DAY SURGERY or RURAL HEALTH.
  - **UB92 Printer**: Set to the appropriate printer.
  - **UB92 Switch Paper**: Program will ask you to switch to paper during Claims Processing if checked.
  - **Site Uses UB92**: Check this for UB92s.

1.3 Company Table

- Determine the method to be used as discussed in the introduction.
- **Claim format:** Set accordingly.
- **Facility Type:** Choose appropriate Facility type.

1.4 Manage Claim Rules

- Choose the appropriate Claim Rule for the type of insurance plans that use UB92
- Go through the UB92 Rules and mark appropriate fields/format to print on UB92.
- Note: The fields “ICDCM Box 79 In/Outpatient”: If you choose “Y-Use ICD9CM” the program will print a 9 in box 79. If you choose “N-Use CPT4” the program puts a 4 in box 79.
- Include POA Section: See note on Miscellaneous Tab section of Charge Entry.
- Default Claim Rule example is listed below:

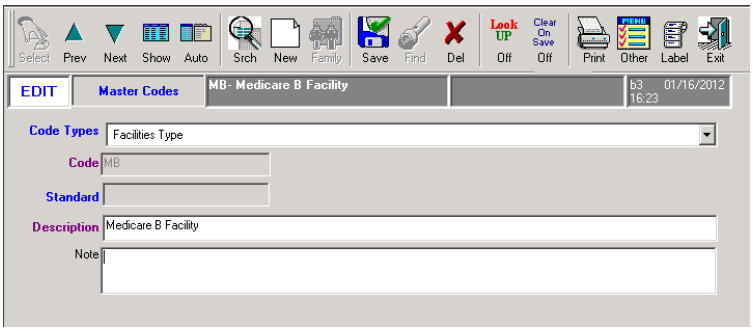


1.5 Procedures Table

- **Rev. Code:** Manually enter the UB92 revenue code (typically **490**) in this field for all CPTs that will print to a UB92. This will print in box 42 of the UB92 form.
- **DRG Codes:** Complete these codes type “DRG” as required for the practice. These codes are used in the DRG drop down list section of the Charge Entry >> UB92 tab.

1.6 Master Codes Table

- **UB92 Condition Codes:** Complete these codes as required for the practice. These codes are used in the CONDITION CODE drop down list section of the Charge Entry >> UB92 tab.
- **UB92 Occurrence Codes:** Complete these codes as required for the practice. These codes are used in the OCCURANCE CODE drop down list section of the Charge Entry >> UB92 tab.
- **UB92 Value Codes:** Complete these codes as required for the practice. These codes are used in the VALUE CODE drop down list section of the Charge Entry >> UB92 tab.
- **Added the ability to bill using 121 as Type of Bill for UB claims.** Users now have the ability to bill UB claims with Type of Bill (TOB) 121. TOB 121 is designed for inpatient Medicare claims where patients can only utilize Medicare Part B after exhausting Medicare Part A coverage. Before TOB 121 can be utilized for UB claims, a Medicare B Facility Type code must be created within the *Master Codes* table.

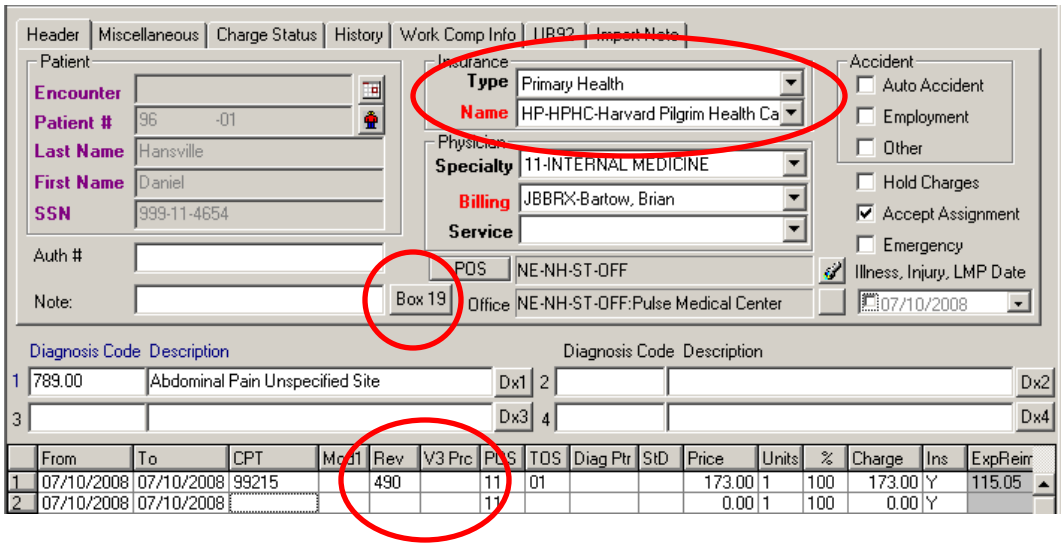


1.7 Insurance Table

- **Insurance Plan Format:** Format must be UB92 for ANY plan that requires a UB92. The program will check the plan and company when creating a claim and if the Company claim format equals UB92 and Plan Format equals UB92 then a UB92 will print. If the Company claim format equals HCFA then a HCFA will print regardless of the Plan Format.
- *Note: UB92's typically prints to paper, if the client requests to be setup to go electronically you no longer need to setup another clearinghouse for UB92 format. The client should have been enrolled appropriately for UB92 claims. (See the XMIT ENVOY.doc if you are sending claims to Emdeon, there are different prompt responses for sending Facility claims.)*

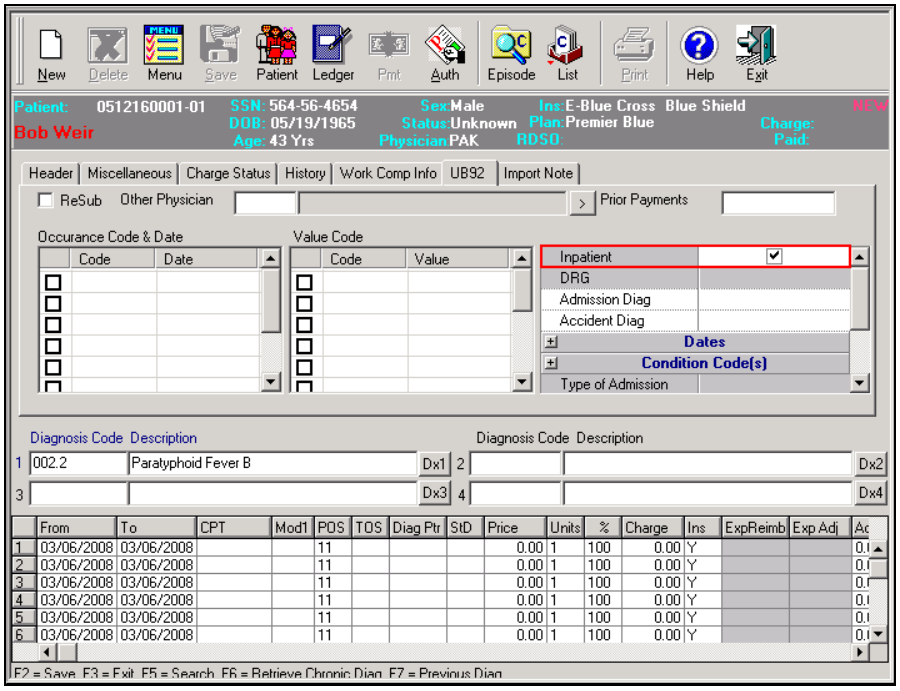
1.8 Charge Entry

- **Charge Entry Header:**

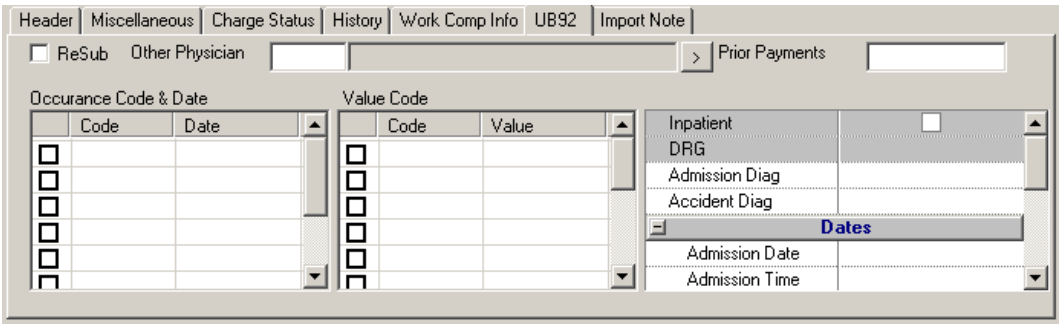


- **Insurance Name:** if using the One Company option then instruct poster to select the correct insurance policy for the format required for the facility being posted.
- **Box 19:** Notes placed in this area will appear in **Box 84 Remarks** on the UB form.
- **Rev:** UB92 Rev Code from procedure table.
- **V3 Prc:** Volume 3 Procedure Codes. Typically used for inpatient Hospital Billing.
    - The International Classification of Diseases, Clinical Modification (ICD-9-CM), is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization in the U.S. **Volume 3 (procedures) is used in assigning codes associated with inpatient procedures (Hospitals)**. The ICD-9-CM is based on the ICD but provides for additional morbidity detail and is annually updated.

- **Miscellaneous Tab:**
  - Effective October 1, 2007, Medicare began to accept a *Present on Admission* (POA) indicator for every diagnosis on inpatient acute care hospital claims. On January 1, 2008, Medicare started sending remittance advice remark codes informing hospitals that they failed to report a valid POA code when a discharge was reported. As of April 1, 2008 (for discharges), Medicare began to return claims when a valid POA code is not submitted for each diagnosis. The charge record would need to be adjusted to indicate the correct POA code and the claim resubmitted. Critical access hospitals, Maryland waiver hospitals, long-term care hospitals, cancer hospitals, psychiatric hospitals, inpatient rehabilitation facilities, and children's inpatient facilities are exempt from this requirement.
  - Within the *Diagnosis* field on the *Miscellaneous* tab, click the **POA** column and select the appropriate indicator.
  - Add up to 8 diagnosis and reference 1 thru 8 on the Header tab in the Diag Ptr field.



- **UB92 Tab:** Additional UB92 information can be entered for Occurrence Codes, Value Codes, Prior Payments, DRG codes, etc. that correspond with the boxes on the UB form. Most practices are not required to fill in this information but these fields are available as required.



1.9 UB92 Occurrence and Value Codes

	50 – UB92 Occurrence Codes – claim form boxes 31-36
Code	**Description**
01	Auto Accident
02	No Fault Insurance Involved-Including Auto Accident/Other
03	Accident/Tort Liability
04	Accident/Employment Related
05	Other Accident
06	Crime Victim
09	Start of infertility treatment cycle
10	Last menstrual period
11	Onset of symptoms/illness
12	Date of onset for a chronically dependent individual
16	Date of last therapy
17	Date outpatient occupational therapy plan established
18	Date of retirement — patient/beneficiary
19	Date of retirement — spouse
20	Date guarantee of payment began
21	Date UR notice received
22	Date active care ended
23	Date of cancellation of hospice election period
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Payer
26	Date SNF bed became available
27	Date of Hospice Certification or Precertification
28	Date comprehensive outpatient rehab plan established

29	Date outpatient physical therapy plan established
30	Date outpatient speech pathology plan established
31	Date beneficiary notified of intent to bill accommodations
32	Date beneficiary notified of intent to bill procedures
33	First day of Medicare coordination period — ESRD beneficiaries
34	Date of election of extended care facilities
35	Date treatment started for physical therapy
36	Date of inpatient hosp discharge — covered transplant patient
37	Date of inpatient hospital discharge — noncovrd transplant patient
38	Date Treatment Started for Home IV Therapy
39	Date discharged on a continuous course of IV therapy
40	Scheduled date of admission
41	Date of first test preadmission testing
42	Date of Discharge
43	Scheduled Date of Canceled Surgery
44	Date treatment started occupational therapy
45	Date treatment started for speech therapy
46	Date treatment started for cardiac rehabilitation
47	Date cost outlier status begins
A1	Birthdate — Insured A
A2	Effective Date — Insured A Policy
A3	Benefits exhausted
B1	Birthdate — Insured B
B2	Effective Date — Insured B Policy
B3	Benefits exhausted
C1	Birthdate — Insured C
C2	Effective Date — Insured C Policy
C3	Benefits exhausted

E1	Birthdate — insured D
E2	Effective date — insured D policy
E3	Benefits exhausted
F1	Birthdate — insured E
F2	Effective date — insured E policy
F3	Benefits exhausted
G1	Birthdate — insured F
G2	Effective date — insured F policy
G3	Benefits exhausted
M0	PRO/UR Stay Dates
M1	Provider Liability — No Utilization
M2	Dates of Inpatient Respite Care
M3	ICF level of care
M4	Residential level of care

	51 – UB92 Value Codes – claim form boxed 39-41
Code	**Description**
01	Most common semi-private rate
02	Hospital has no semi-private rooms
04	Inpatient professional component charges
05	Professional component included in charges
06	Medicare blood deductible
07	Reserve for national assignment
08	Medicare lifetime reserve amount in the first calendar year
09	Medicare coinsurance amount first calendar year
10	Lifetime reserve amount in the second calendar year
11	Coinsurance amount in the second calendar year
12	Working aged beneficiary with employer group health plan

13	ESRD beneficiary in a Medicare coordination period
14	No-fault
15	Worker’s compensation
16	PHS, or other federal agency
21	Catastrophic
22	Surplus
23	Recurring monthly income
24	Medicaid rate code
25	Offset to the patient-payment amount — prescription drugs
26	Offset to the patient-payment amount — hearing & ear svcs
27	Offset to the patient-payment amount — vision & eye svcs
28	Offset to the patient-payment amount — dental svcs
29	Offset to the patient-payment amount — chiropractic svcs
30	Preadmission testing
31	Patient liability amount
32	Multiple-patient ambulance transport
33	Offset to the patient-payment amount — podiatric svcs
34	Offset to the patient-payment amount — other service
35	Offset to the patient-payment amount — health ins premium
37	Pints of blood furnished
38	Blood deductible pints
39	Pints of blood replaced
40	New coverage not implemented by HMO
41	Black lung
42	VA
43	Disabled beneficiary under age 65 for LGHP
44	Amount provider agreed to accept from primary payer
45	Accident hour

46	Number of grace days
47	Any liability insurance
48	Hemoglobin reading
49	Hematocrit reading
50	Physical therapy visit
51	Occupational therapy visits
52	Speech therapy visits
53	Cardiac rehab visits
54	Newborn birth weight in grams
55	Eligibility threshold for charity care
56	Skilled nurse — home visit hours
57	Home health aide — home visit hours
58	Arterial blood gas
59	Oxygen saturation
60	HHA branch MSA
61	Location where service is furnished
66	Medicaid spenddown amount
67	Peritoneal dialysis
68	EPO drug
69	State charity care percent
73	Drug deductible
74	Drug coinsurance
81	Medicare Part B — Charges when Part A exhausted
83	Medicare Part A — Charges when Part A exhausted
A0	Special ZIP code reporting
A1	Deductible payer A
A2	Coinsurance payer B
A3	Estimated responsibility payer A

A4	Covered self-administrable drugs — emergency
A5	Covered self-administrable drugs — not self administrable
A6	Covered self-administrable drugs — diagnostic study & other
A7	Copayment, payer A
A8	Patient weight
A9	Patient height
AA	Regulatory surcharges, assessments, allowances, payer A
AB	Other assessments or allowances, payer A
B1	Deductible payer B
B2	Coinsurance, payer B
B3	Estimated responsibility, payer B
B7	Copayment, payer B
BA	Regulatory surcharges, assessments, allowances, payer B
BB	Other assessments or allowances, payer B
C1	Deductible, payer C
C2	Coinsurance, payer C
C3	Estimated responsibility, payer C
C7	Copayment, payer C
CA	Regulatory surcharges, assessments, allowances, payer C
CB	Other assessments or allowances, payer C
D3	Estimated responsibility, client
E1	Deductible, payer D
E2	Coinsurance, payer D
E3	Estimated responsibility, payer D
E7	Copayment, payer D
EA	Regulatory surcharges, assessments, allowances, payer D
EB	Other assessments or allowances, payer D
F1	Deductible, payer E

F2	Coinsurance, payer E
F3	Estimated responsibility, payer E
F7	Copayment, payer E
FA	Regulatory surcharges, assessments, allowances, payer E
FB	Other assessments or allowances, payer E
G1	Deductible, payer F
G2	Coinsurance, payer F
G3	Estimated responsibility, payer F
G7	Copayment, payer F
GA	Regulatory surcharges, assessments, allowances, payer F
GB	Other assessments or allowances, payer F
Y1	Part A demonstration payment
Y2	Part B demonstration payment
Y3	Part B coinsurance
Y4	Conventional provider payment amount for non-demonstration claims

1.10 UB92 Form

1.11 UB04 Form