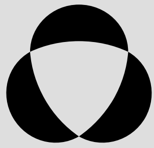

Washington State Department of
Labor & Industries
Workers' Compensation Services

Hospital Services Billing Manual

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Hospital Services Billing Manual

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About Billing Instructions

Where can you find help with L&I billing procedures?

Labor & Industries (L&I) provides resources to help you understand and comply with the Industrial Insurance laws in the Revised Code of Washington (RCW) and the Washington Administrative Code (WAC).

L&I publishes the Medical Aid Rules and Fee Schedule (MARFS) which has the payment policies and fees schedule. You can find MARFS online at www.Lni.wa.gov/apps/FeeSchedule.

In additional, L&I publishes a general billing manual and one billing manual for each bill form. Below is a list of the billing manuals L&I provides:

- General Provider Billing Manual.
- CMS 1500 Billing Manual.
- Home and Residential Care Billing Manual.
- Hospital Billing Instructions.
- Miscellaneous Services Billing Instructions.
- Pharmacy Billing Instructions.
- Retraining and Job Modification Billing Instructions.

Each manual includes the following information:

- Information about Industrial Insurance and Crime Victims.
- Electronic and paper billing information.
- How to complete the bill forms.
- Where to send bill forms.
- Billing examples.
- Links to billing forms.

About Labor & Industries (L&I) Industrial Insurance

As administrator of Washington State's workers' compensation system, L&I is similar to a large insurance company that provides claim-related coverage to workers who suffer job-related injuries and illnesses.

Two programs cover Washington's industrially injured/ill workers: the Washington State Fund and the Self Insured Employer Program (SIE). Both programs are governed by the Revised Code of Washington (RCWs) and the Washington Administrative Code (WACs).

State Fund Industrial Insurance

The Washington State Fund is financed by premiums from employers, workers, and income from investments. L&I claim managers oversee State Fund benefits to workers who are injured or become ill on the job. The State Fund covers all employers in the state who are not self-insured or covered by the U.S. Department of Labor.

State Fund claim numbers begin with one letter (B, C, F, G, H, J, K, L, M, N, P, X, Y, or Z) followed by 6 numbers or two letters (AA, AB) followed by 5 numbers. Example state fund claim numbers include: B123456 or AM95370.

Additional information about billing State Fund can be found in this manual or online at www.Lni.wa.gov/ClaimsIns/Providers/Billing or you can call the Provider Hotline at 800-848-0811.

Self-Insured Employer Program

L&I regulates about 400 large, self-insured employers (SIE) who have qualified to provide their own workers' compensation insurance. Every SIE must authorize medical treatment and pay bills in accordance with Title 51 RCW and the Medical Aid Rules and Fee Schedules of the State of Washington per WAC 296-15-330(1).

Self-Insured claim numbers all start with S, T, or W followed by 6 numbers or 2 letters followed by 5 numbers. Example self-insured claim numbers include T123456 or SG12345.

For a list of self-insured employers, please go to www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp.

Additional information about billing for self-insured claims can be directed to the employer or their third party administrator (TPA).

Getting Paid for Services Provided to Washington Workers

Every provider who treats injured workers must have an active provider payment account with L&I to be eligible for payment (WAC 296-20-015). Please visit L&I's website for detailed information about becoming an L&I provider at www.Lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp.

State Fund Electronic Billing

There are 3 ways to bill electronically for state fund claims:

1. Direct Entry using a free online form.

2. Upload billing files using your own software.

3. Submit bills through a Clearinghouse.

L&I offers free electronic billing through Provider Electronic Billing (PEB). PEB saves time and money and allows for greater control over the payment process, eliminates entry time, and allowing to process payments faster than paper billing. PEB reduces keying errors and decreases bill processing costs.

You can find detailed PEB information on our website at www.Lni.wa.gov/ElectronicBilling.

You can also find a Cost Comparison Estimator for electronic billing at www.Lni.wa.gov/ClaimsIns/Files/Providers/EstimatorFinal042009.xls.

Self-Insurance Electronic Billing

Please contact the employer or their TPA for billing information.

State Fund Paper Billing

The type of service you provide determines which billing form you need to use. See a list of a bill requirements for each provider type in the General Provider Billing Manual – page 7.

You must submit your bills on L&I approved bill forms. Please ***don't fax*** your bills. Mail your bills to the address below:

Department of Labor & Industries
PO Box 44269
Olympia WA 98504-4269

Self-Insurance Paper Billing

You must submit your bills on L&I or self-insured approved forms (WAC 296-20-125(1)).

Mail your bills directly to the SIE or TPA. For a list of SIE/TPAs and their contact information, please visit: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsurance/EmpList.

Crime Victims Compensation Program

The Crime Victims Compensation Program is a secondary insurance program that provides financial, medical, and mental health benefits to victims of crimes.

Crime Victims claim number begin the letter V followed by 6 digits or a 2 letters, such as VA, followed by 5 digits.

Additional information about the Crime Victims Compensation Program can be found online at www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources or by calling the Crime Victims Compensation Program at 360-902-5377 or 800-762-3716.

Getting Paid for Services Provided to Crime Victims

You can find Crime Victims billing forms online at: www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources.

Please ***don't fax*** your bills to Crime Victims Compensation Program. Mail your bills to:

Department of Labor & Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

Hospital Services Billing Instructions

Hospital Services Rules and Policies

Rules and policies for billing payment for hospital services are explained in WAC chapter 296-19A; 296-20; 296-21; 296-23; 296-23A; 296-23B and the Medical Aid Rules and Fee Schedules Chapter 35, which are available online at www.Lni.wa.gov/FeeSchedules.

You can bill the department using the CMS 1450 form or the 837 I for electronic billing.

Out-of-State Hospital Payment Methods

See WAC 296-23A-0230 for out-of-state hospital outpatient, inpatient, and professional services payment methods.

*Hospitals not in Washington State are paid by an out-of-state POAC factor. Effective **July 1, 2015**, the rate is **59.8% for hospitals within the United States and 100% for out-of-country hospitals.***

Same Day Bills

Hospital bills for patients admitted and discharged the same day may be treated as outpatient bills (see the Medical Aid Rules and Fee Schedules www.Lni.wa.gov/FeeSchedules for exclusions). Hospitals are responsible for establishing criteria to define inpatient and outpatient services stays beyond the same day.

Radiology, Pathology, and Laboratory

Hospitals are reimbursed only for the technical component for outpatient radiology, pathology, and laboratory services.

Policy Changes

Hospitals are notified of changes to payment methods and policies via the Medical Aid Rules and Fee Schedules and the L&I Medical Provider e-News listserv. To sign up to receive updates on the L&I Medical Provider e-News listserv, go to www.Lni.wa.gov/Main/Listserv/Providers.asp.

Specific individual hospital rates are announced via letter sent to hospital administrators.

To obtain information concerning the current hospital payment policies and rates, please visit www.Lni.wa.gov/FeeSchedules.

Supporting Documentation

Supporting documentation is required to substantiate billings for both hospital inpatient and outpatient services. Bills submitted without supporting documentation may be returned or denied.

The worker's signature on the Report of Industrial Injury or Occupational Disease (ROA) provides hospitals and other providers with the authority to release medical records to the department.

Please be certain the worker's name and the claim number are in the upper right corner of each page of the documentation.

For inpatient bills submitted, the following documents are required:

a) Admission history and physical examination
b) Discharge summary for stays over 48 hours
c) Emergency room reports
d) Operative reports
e) Anesthesia records
f) Other documentation as requested by L&I or the self-insurer.

For outpatient bills, only the following documents are required:

a) Emergency room reports
b) Operative reports
c) Other documentation as requested by L&I or the self-insurer.

Fax supporting documentation to 360-902-4567. *See the Supporting Documentation Fax Cover Sheet as the end of this manual.*

NOTE – Faxed documents go directly to the claim file while mailed documents take several days to process to the claim file.

You can mail the supporting documentation to the address listed below. ***Supporting documentation must be mailed separately from the bill.***

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

L&I does not accept faxed bills. You can mail your bill and adjustments requests to:

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

Medical Record Copy Fees

No photocopy service fee may be billed for documentation submitted to support billing for services provided.

We will pay for copies of medical records requested by L&I for information relevant to the adjudication of a specific claim.

The cost for copying medical records must be billed by the hospital. Bills submitted by service companies will be denied.

Bill Reviews

Most inpatient bills and some outpatient bills are reviewed for medical necessity and relationship to accepted conditions prior to payment rather than after payment is made. However, we may also retrospectively review selected bills.

All inpatient bills require prior authorization. This includes admissions for 24-hour observation that are billed as inpatient services (using second digit code 1, Form Locator 4). All inpatient bills will be evaluated for length-of-stay and severity of illness criteria.

When there are questions, full documentation may be requested. We will notify you in these circumstances.

Bill Submission Requirements

All charges for hospital inpatient and outpatient services provided to workers must be submitted on the UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications.

Adjustments

Any changes to a paid or partially paid bill must be made on L&I's Provider's Request for Adjustment form (F245-183-000). Please reference the original bill's identifier – the Internal Control Number (ICN).

The Provider's Request for Adjustment (F245-183-000) is available online at www.Lni.wa.gov/FormsPubs.

Professional Services

Physician or nursing professional services must be billed on the CMS 1500 billing form.

A copy of the CMS 1500 is available online at www.Lni.wa.gov/FormsPubs.

UB-04 CMS 1450 Billing Instructions

L&I Provider Account Numbers and National Provider Identifiers

Hospitals must have an active L&I provider payment number to bill for services and must have registered their National Provider Identified (NPI) with L&I prior to its use on L&I bills.

Enter your NPI in Form Locator 56 and/or the L&I provider payment number in Form Locator 57A. When submitting an NPI, be sure to include the complete address and zip code information in Form Locator 1 and Federal Tax Identification in Form Locator 5.

Note – Hospitals may submit either their NPI (if registered with L&I) or their L&I provider payment number on the billing form.

L&I assigns one hospital provider payment number for all UB-04 CMS 1450 bills that cover acute services, psychiatric, rehabilitation, substance abuse, and outpatient services.

Additional Provider Payment Numbers Required

Hospital must obtain additional L&I provider payment number to bill for each of the following services:

- Physician or Nursing Professional Fees (billed on the CMS 1500 form).
- Ambulance/air transportation services (billed on L&I Statement for Miscellaneous Services).
- Take home pharmacy items (billed through the L&I Point of Sale system).
- Pain Management Services (billed on the UB-04 CMS 1450)

Call our Provider Credentialing and Compliance at 360-902-5140 or visit www.Lni.wa.gov/Providers to obtain an application for additional L&I provider payment numbers. You may also update your account to include your NPI information.

L&I Claim Number

Enter the L&I assigned claim number for the worker being treated in Form Locator 62.

Omission of this number will result in denial of payment

State Fund claim numbers are alpha-numeric consisting of 7 characters. They begin with B, C, D, F, G, H, J, K, L, M, N, P, X, Y, or Z followed by 6 digits or double alpha character (e.g. AA, AB) followed by 5 digits.

IMPORTANT – The next section of information contains the reference to ICD-9 codes. It may also apply to ICD-10 when they are adopted.

ICD-9-CM

Enter the correct diagnosis codes in Form Locator 67, 67A-Q, and the correct procedure codes in Form Locator 74, 74a-e. Include leading zeroes of appropriate.

The ICD-9-CM Coding Handbook for Entry Level Coders describes the level of specification in coding required.

- Enter the ICD-9-CM code for the principal diagnosis in Form Locator 67.
  - The principal diagnosis is the condition established after study to be chiefly responsible for causing this hospitalization.
  - Do not use the code accepted by L&I for the claim unless it is the **principal diagnosis** established by medical records for this hospitalization.
- Use the most detailed code.
- Use only valid ICD-9-CM codes until the adoption of the ICD-10 codes later this year.
- ICD-9-CM codes that are not specific or invalid will be denied. For example: 848.9 Sprain NOS.
- Report three or four digit codes **only if** further subdivisions are not available.
- If three or four digit codes have subdivisions, report the appropriate subdivision code.

Treatment Authorization Number (For Inpatient and Targeted Outpatient Procedures)

Enter the treatment authorization number in Form Locator 63.

Providers are required to comply with L&I's inpatient pre-admission review program. If circumstances prevent a call prior to admission, please call as early as possible during the admission, as concurrent review may still be possible. Failure to verify authorization may result in delayed or denied payment.

Utilization Review procedures can be found online at www.Lni.wa.gov/ClaimIns/Providers/AuthRef/UtilReview.

Our Utilization Review Notification Lines are available nationwide:

Phone: 800-541-2894 (toll free) or 206-366-3360
Fax: 877-665-0383 (toll free) or 206-366-3378

L&I Hospital Inpatient/Outpatient Utilization Review (UR) Program includes prior authorization for inpatient admissions and targeted outpatient surgical and diagnostic procedures for:

- Physical and Occupation Therapy (for visits over 24)
- Length of stay and continued stay evaluation for inpatient admission
- Discharge coordination

Admitting physicians must call L&I's contracted UR firm to request an authorization number for an inpatient admission or outpatient procedure prior to all non-emergent, elective hospital inpatient stays, including these admissions:

- Rehabilitation treatment (other than inpatient pain clinic treatment)
- Acute care inpatient psychiatric treatment

Utilization Review procedures can be found online at www.Lni.wa.gov/ClaimIns/Providers/AuthRef/UtilReview.

An authorization number does not guarantee payment. Payment is contingent upon the authorization and eligibility of the worker by the claim manager. Hospital should verify authorization with admitting the doctor or by calling:

- The Claim Information System: **1-800-831-5227**
- The L&I Service Location nearest to you: **Go to:** www.Lni.wa.gov/Offices.
- The Provider Hotline: **1-800-848-0811**

Critical Access Hospitals Using Swing Bed for Sub-Acute Care

Critical Access Hospitals will be paid for swing bed services utilizing a hospital-specific POAC rate.

You may contact an occupation nurse consultant (ONC) for approval to obtain information for contacting the nurse consultant call the Provider Hotline at 1-800-831-5227.

Upon approval from an L&I ONC, Critical Access Hospitals should bill their usual charge for sub-acute care (swing bed use) on the UB-04 billing form. Identify these services in the Type of Bill field (Form Locator 04) with 018x series (Hospital Swing Beds).

UB-04 CMS 1450 Billing Detail

The following information is required by L&I on bills for services provided to workers.

Notes: All fields are required unless otherwise noted.

Bill Type Field:

I = Inpatient bills
O = Outpatient bills

Form Locator	Bill Type	Information Required (Unless Otherwise Specified)
1	I/O	Provider Name, Address, Zip Code, and Telephone Number
2	I/O	Pay to Name and Address
3a	I/O	Patient Control Number (Hospital Account Number)
3b	I/O	Medical/Health Record Number
4	I/O	Type of Bill This four-digit alphanumeric code gives three specific pieces of information after a leading zero. Labor and Industries will ignore the leading zero (1st digit) and will continue to process three specific pieces of information. Indicate type of bill using the remaining three digits as follows: **2nd Digit – Type of Facility:** 1 – Hospital, includes swing beds 2 – Skilled Nursing 3 – Home Health 4 – Religious Non-Medical 5 – Intermediate Care 7 – Clinic or Hospital Based Renal Dialysis 8 – Special Facility or Hospital ASC Surgery ***Notes for Type of Facility (2nd digit) and Bill Classification (3rd digit)*** • If code 7 is used, then the Bill Classification (Clinics Only) – 3rd digit must be used. • If code 8 is used, then the Bill Classification (Special Facility Only) – 3rd digit must be used.

		3rd Digit – Bill Classification (Except Clinic and Special Facilities) 1 – Inpatient (Medicare Part A) – Either 1 or 2 will work for L&I inpatient bills. 2 – Inpatient (Medicare Part B Only) 3 – Outpatient 4 – Other (for hospital reference diagnostic services, or home health not under plan of treatment). 5 – Intermediate Care – Level I*** 6 – Intermediate Care – Level II*** 8 – Swing Bed **3rd Digit – Bill Classification (Clinics Only – must be used the Type of Facility Code 7)** 1 – Rural Health 2 – Hospital Based or Independent (Free Standing) Renal Dialysis Center 3 – Free Standing 4 – Other Rehabilitation Facility (ORF) 5 – Comprehensive Outpatient Rehabilitation Facility (CORF) 9 – Other **3rd Digit – Bill Classification (Special Facilities Only – must be used with the Type of Facility Code 8)** 1 – Hospice (non-hospital based) 2 – Hospice (hospital based) 3 – Ambulatory Surgery Center 4 – Free Standing Birthing Center 5 – Critical Access Hospital 9 – Other **4th Digit – Frequency** 1 – Admit through Discharge Claim 2 – Interim – First Claim 3 – Interim – Continuing Claim 4 – Interim – Last Claim 5 – Late Charge(s) – *Note: Late charges will not be paid after bill has been audited* ***Note for Frequency (4th Digit): L&I recognizes the 4th digit in this Form Locator, however, adjustments to previously paid bills must be submitted on L&I's Provider's Request for Adjustment form.*** ***Note – Interim billing is discouraged.***
5	I/O	Federal Tax Number

6	I/O	Statement Covers Period Enter the beginning and end dates (MMDDYY) of the period included on this bill. Enter the admission and discharge dates if the bill is for an inpatient admission and patient was discharged.
8b	I/O	Patient Name Enter the worker's last name, first name, and middle initial.
9a – d	I/O	Patient Address Enter the worker's street address, city, state, and zip code.
10	I/O	Patient Birthdate Enter the worker's date of birth in the mm/dd/yyyy format.
11	I/O	Patient Sex
12	I/O	Admission Date Enter the admission date in the mm/dd/yyyy format.
13	I/O	Admission Hour This information is not required and will not be used.
14	I/O	Type of Admission 1 = Emergent 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 9 = Information not available
15	I/O	Source of Admission This information is not required and will not be used.
16	I/O	Discharge Hour This information is not required and will not be used.
17	I/O	Patient Status 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) 04 = Discharged/transferred to an immediate care facility (ICF) 05 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list.

06 = Discharged/transferred to home under the care of organized home health service organization.

07 = Left against medical advice or discontinued care

09 = Admitted as an inpatient to this hospital

20 = Expired

21 = Discharged/transferred to Court/Law Enforcement

30 = Still patient

43 = Discharged/transferred to federal health care facility

50 = Hospice – home

51 = Hospice – medical facility (certified) providing hospice level of care

61 = Discharged/transferred within this institution to hospital-based Medicare approved swing bed

62 = Discharged/transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital

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

64 = Discharged/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

66 = Discharged/transferred to a critical access hospital (CAH)

69 = Discharges/transferred to Designated Disaster Alternative Care Site

70 = Discharged/transferred to another Type of HealthCare Institution Not Defined Elsewhere in this Codes List

81 = Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission

82 = Discharged/transferred to Short Term General Hosp for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission

83 = Discharged/transferred to SNF with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission

84 = Discharged/transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission

85 = Discharged/transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission

86 = Discharged/transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission

87 = Discharged/transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission

88 = Discharged/transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission

		89 = Discharged/transferred to a Hospital Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
18-28	I/O	Condition Codes Required if applicable.
29	I/O	Accident State This information is not required and will not be used.
31-34	I/O	Occurrence Codes and Dates This information is not required and will not be used.
35-36	I/O	Occurrence Span Codes and Dates This information is not required and will not be used.
38	I/O	Responsible Party Name and Address This information is not required and will not be used.
42	I/O	Revenue Codes [Only National Revenue Codes are used]
43	I/O	Revenue Codes Description Enter the narrative description of the revenue code or HCPCS procedure code when required
44	I/O	HCPCS/Rates/HIPPS Rate Codes • Enter the accommodation rate for inpatient bills or • Enter the CMS Common Procedure Coding System (HCPCS) code and modifiers applicable to services for outpatient bills. (See table for revenue codes requiring CPT/HCPCS)
45	O	Service Date Enter the Service Date in mm/dd/yy format
46	I/O	Service Units
47	I/O	Total Charges
48	I/O	Non-Covered Charges
50	I/O	Payer Identification – Name This information is not required and will not be used.
51	I/O	Health Plan Identification Number This information is not required and will not be used.
52	I/O	Release of Information Certification Indicator This information is not required and will not be used.
53	I/O	Assignment of Benefits Certification Indicator This information is not required and will not be used.
54	I/O	Prior Payments – Payer This information is not required and will not be used.
55	I/O	Estimated Amount Due – Payer This information is not required and will not be used.
56	I/O	National Provider Identifier – Billing Provider

57	I/O	Other Provider Identifier 57 A Enter Labor and Industries provider number
58	I/O	Insured's Name
59	I/O	Patient's Relationship to Insured This information is not required and will not be used.
60	I/O	Insured's Unique Identification This information is not required and will not be used.
61	I/O	Insured Group Name This information is not required and will not be used.
62	I/O	Insurance Group Number Enter the L&I claim number of the worker
63	I/O	Treatment Authorization Code *For more information, see pages 7 – 8 of this billing instruction*
64	I/O	Document Control Number (DCN) This information is not required and will not be used.
65	I/O	Employer Name • Required when a patient's employer is a Self-Insured firm • Not required for State Fund Claimants. If submitted, the data will be ignored.
66	I/O	Diagnosis and Procedure Code Qualifier (ICD Version Indicator) This information is not required and will not be used.
67	I/O	Principal Diagnosis Code Enter only valid ICD-9-CM codes
67 A-Q	I/O	Other Diagnosis Codes Enter only valid ICD-9-CM codes
69	I	Admitting Diagnosis Codes Enter only valid ICD-9-CM codes
70 a-c	O	Patient's Reason for Visit Enter only valid ICD-9-CM codes
71	I/O	Prospective Payment System (PPS) Code This information is not required and will not be used.
72	I/O	External Cause of Injury (ECI) Code
74	I/O	Principal Procedure Codes and Dates • Enter only valid ICD-9-CM codes for inpatient bills • Enter only valid CPT or HCPCS codes for outpatient bills
74 a-e	I/O	Other Procedures and Dates • Enter only valid ICD-9-CM codes for inpatient bills • Enter only valid CPT or HCPCS codes for outpatient bills
76	I/O	Attending Provider Name and Identifiers Not required. If submitted, the data will be ignored.
77	I/O	Operating Physician Name and Identifiers This information is not required and will not be used.

78-79	I/O	Other Provider Name and Identifiers This information is not required and will not be used.
80	I/O	Remarks Field *NOTE: Use only when applicable. Inappropriate use of Remarks will unnecessarily cause suspense of bills.*
81	I/O	Code-Code (CC) Field Enter Code List Qualifier and provider taxonomy code.

Revenue Codes Requiring CPT/HCPCS Codes on Outpatient Bills

Hospital paid by the Ambulatory Payment Classification (APC) system are required to submit CPT/HCPCS codes on each line item for which the Outpatient Code Editor requires them. Non-APC hospitals are strongly encouraged to supply CPT/HCPCS codes on **each** line item as well, but are **required** to do so for the revenue codes in the revenue code table (next table in this document).

Since the CPT/HCPCS codes are more specific than the revenue codes, services and charges which fall within one revenue code may need to be broken down in more than one line item. You may need to break down each line item, repeating the **same** revenue code on multiple bill lines with **different** CPT/HCPCS codes.

On the UB-04 CMS 1450 form:

- Enter the revenue codes in Form Locator 42.
- Enter the CPT/HCPCS codes in Form Locator 44.
- Enter the appropriate units of service for each valid CPT or HCPCS code or number of items supplied in Form Locator 46. Consult the appropriate coding books for additional information.

National Revenue Codes with Instructions

L&I uses the National Revenue Codes maintained by the National Uniform Billing Committee. For a complete list of the National Revenue codes, please refer to www.nubc.org.

The following table contains *ONLY* the National Revenue codes which have special instructions and is not inclusive of all revenue codes which may be billed.

Revenue Code	Description	Special Provider Instructions	L&I
19X	Subacute Care	None	Covered
25X	Pharmacy	Yes – Not to be used to dispense for home use	Covered
256	Experimental Drugs		Not usually covered
26X	IV Therapy	None	Covered
27X	Medical/Surgical Supplies and Devices	None	Covered
28X	Oncology	None	Covered
29X	Durable Medical Equipment (other than rental)	None – Requires a separate L&I provider number	Covered
30X	Laboratory		Covered
300	General Classification	HCPCS code required for outpatient	Covered
301	Chemistry	HCPCS code required for outpatient	Covered
302	Immunology	HCPCS code required for outpatient	Covered
303	Renal Patient (home)	HCPCS code required for outpatient	Covered
304	Non-Routing Dialysis	HCPCS code required for outpatient	Covered

Revenue Code	Description	Special Provider Instructions	L&I
305	Hematology	HCPCS code required for outpatient	Covered
306	Bacteriology & Microbiology	HCPCS code required for outpatient	Covered
307	Urology	HCPCS code required for outpatient	Covered
309	Other Laboratory	HCPCS code required for outpatient	Covered
31X	Laboratory – Pathology		Covered
310	General Classification	HCPCS code required for outpatient	Covered
311	Cytology	HCPCS code required for outpatient	Covered
312	Histology	HCPCS code required for outpatient	Covered
314	Biopsy	HCPCS code required for outpatient	Covered
319	Other	HCPCS code required for outpatient	Covered
32X	Radiology – Diagnostic		Covered
320	General Classification	HCPCS code required for outpatient	Covered
321	Angiocardiography	HCPCS code required for outpatient	Covered
322	Arthrography	HCPCS code required for outpatient	Covered
323	Arteriography	HCPCS code required for outpatient	Covered
324	Chest X-Ray	HCPCS code required for outpatient	Covered
329	Other	HCPCS code required for outpatient	Covered
33X	Radiology – Therapeutic	HCPCS code required for outpatient	Covered
330	General Classification	HCPCS code required for outpatient	Covered
331	Chemotherapy – Injected	HCPCS code required for outpatient	Covered
332	Chemotherapy – Oral	HCPCS code required for outpatient	Covered
333	Radiation Therapy	HCPCS code required for outpatient	Covered
335	Chemotherapy – IV	HCPCS code required for outpatient	Covered
339	Other	HCPCS code required for outpatient	Covered
34X	Nuclear Medicine		Covered

Revenue Code	Description	Special Provider Instructions	L&I
340	General Classification	HCPCS code required for outpatient	Covered
341	Diagnostic	HCPCS code required for outpatient	Covered
342	Therapeutic – Oral	HCPCS code required for outpatient	Covered
343	Diagnostic Radiopharmaceuticals	HCPCS code required for outpatient	Covered
349	Other	HCPCS code required for outpatient	Covered
35X	CT Scan		Covered
350	General Classification	HCPCS code required for outpatient	Covered
351	Head Scan	HCPCS code required for outpatient	Covered
353	Head Scan	HCPCS code required for outpatient	Covered
359	Other CT Scan	HCPCS code required for outpatient	Covered
36X	Operating Room Services	HCPCS code required for outpatient	Covered
37X	Anesthesia	None	Covered
374	Acupuncture		Not usually covered
40X	Other Imaging Services		Covered
403	Screening Mammography	HCPCS code required for outpatient	Covered
404	Positron Emission Tomography		Non usually covered
41X	RESP	HCPCS code required for outpatient	Covered
42X	Physical Therapy	HCPCS code required for outpatient	Covered
43X	Occupational Therapy	HCPCS code required for outpatient	Covered
44X	Speech Therapy	HCPCS code required for outpatient	Covered
45X	Emergency Room	HCPCS code required for outpatient	Covered
451	EMTALA Emergency Screening Services		Not usually covered
452	ER Beyond EMTALA Screening		Not usually covered
46X	Pulmonary Function	HCPCS code required for outpatient	Covered
47X	Audiology	HCPCS code required for outpatient	Covered
48X	Cardiology	HCPCS code required for outpatient	Covered

Revenue Code	Description	Special Provider Instructions	L&I
49X	Ambulatory Surgical Care	ASC services should be billed on CMS 1500 form	Covered
51X	Clinic	HCPCS code required for outpatient	Covered
53X	Osteopathic Services	HCPCS code required for outpatient	Covered
54X	Ambulance	Bill on Statement for Miscellaneous Services form. Requires a separate L&I provider number.	Covered
55X	Skilled Nursing	Skilled Nursing Services should be billed on the Statement for Miscellaneous Services form.	Covered
57X	Home Health – Home Health Aide		Not usually covered
58X	Home Health – Other Visits		Not usually covered
59X	Units of Service (Home Health)		Not usually covered
60X	Home Health – Oxygen		Not usually covered
609	Other Oxygen		Not usually covered
61X	MRI	HCPCS code required for outpatient	Covered
62X	Medical/Surgical Supplies and Devices	HCPCS code required for outpatient	Covered
624	FDA Investigational Devices		Not usually covered
63X	Drugs Requiring Specific ID		Covered
630	General Classification	HCPCS code required for outpatient	Covered
64X	Home IV Therapy Services		Not usually covered
65X	Hospice Services	HCPCS code required for outpatient	Covered
66X	Respite Care	HCPCS code required for outpatient	Covered
669	Other Respite Care		Not usually covered
67X	Outpatient Special Residence Charges		Not usually covered
70X	Cast Room	HCPCS code required for outpatient	Covered
71X	Recovery Room	None	Covered
72X	Labor Room/Delivery		Not usually covered
723	Circumcision		Not usually covered
73X	EKG/ECG	HCPCS code required for outpatient	Covered
74X	EEG	HCPCS code required for outpatient	Covered
75X	Gastro-Intestinal Services	HCPCS code required for outpatient	Covered

Revenue Code	Description	Special Provider Instructions	L&I
76X	Treatment or Observation Room	HCPCS code required for outpatient	Covered
77X	Preventative Care Services	HCPCS code required for outpatient	Covered
78X	Telemedicine	HCPCS code required for outpatient	Not usually covered
79X	Lithotripsy	HCPCS code required for outpatient	Covered
80X	Inpatient Renal Dialysis	HCPCS code required for outpatient	Covered
81X	Acquisition of Body Components	HCPCS code required for outpatient	Covered
814	Unsuccessful Organ Search – Donor Bank Charges		Not usually covered
82X	Hemodialysis		Not usually covered
822	Home Supplies		Not usually covered
823	Home Equipment		Not usually covered
83X	Peritoneal Dialysis		Not usually covered
832	Home Supplies		Not usually covered
833	Home Equipment		Not usually covered
84X	CAPD		Not usually covered
843	Home Equipment		Not usually covered
85X	CCPD		Not usually covered
852	Home Supplies		Not usually covered
853	Home Equipment		Not usually covered
88X	Miscellaneous Dialysis	HCPCS code required for outpatient	Covered
90X	Psychiatric/Psychological Treatments	HCPCS code required for outpatient	Covered
902	Milieu Therapy	HCPCS code required for outpatient	Covered
904	Activity Therapy	HCPCS code required for outpatient	Covered
91X	Psychiatric/Psychology Services	HCPCS code required for outpatient	Covered
92X	Other Diagnostic Services	HCPCS code required for outpatient	Covered
920	General Classification	HCPCS code required for outpatient	Covered
929	Other Diagnostic Service	HCPCS code required for outpatient	Covered
94X	Other Therapeutic Services		Not usually covered
96X	Professional Fees (Extension of 96X and 97X)	Bill on CMS 1500 using HCPCS	Covered
97X	Professional Fees (Extension of 96X and 97X)	Bill on CMS 1500 using HCPCS	Covered
98X	Professional Fees (Extension of 96X and 97X)	Bill on CMS 1500 using HCPCS	Covered

Revenue Code	Description	Special Provider Instructions	L&I
99X	Patient Convenience Items		Not usually covered
990	General Classification		Not usually covered
991	Cafeteria/Guest Tray		Not usually covered
992	Private Linen Service		Not usually covered
993	Telephone/Telegraph		Not usually covered
994	TV/Radio		Not usually covered
995	Non-patient Room Rentals		Not usually covered
996	Late Discharge Charge		Not usually covered
998	Beauty Shop/Barber		Not usually covered
999	Other Patient Convenience Items		Not usually covered
210X	Alternative Therapy Services		Covered
2103	Massage Therapy	HCPCS code required for outpatient (97124)	Covered