CLAIM EXAMPLES FOR INTERMEDIATE CARE SERVICES FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES (PT 33)

EXAMPLE ~ ICFSN1:
Skilled Nursing Facility billing claim for recipient residing in an intermediate care bed.

Statement Period: 10/01/16 – 10/31/16
Value Code 80 = 31
Legacy Claim Coding:
10/01/16 – 10/31/16 (COS 71)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*314000000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-ICFSN1*5000***65:A:2**A*Y*Y~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*201610011900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189~
HI*BE:23:::500*BE:80:::31~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
LX*1~
SV2*0110**5000*DA*31~
```

REF*6R*EI122215247135640-01~
SE*36*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE -ICFSN1	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0652
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
CHICAGO, IL 60614502		123456789	100116 / 103116	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4		30													

CONDITION CODES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	23	500.00	80	31.00		
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0110	ROOM-BOARD/ PVT		100116	31	5000.00			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	5000.00			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567893
A ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID
B						
C						

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX: Z5189 | I6350 | 68

69 ADMIT DX: M6281 | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC	
	a	B3 314000000X
	b	
	c	
	d	

EXAMPLE ~ ICFSN2:
Skilled Nursing Facility billing claim for recipient residing in an intermediate care bed with leave of absence days.

Statement Period: 10/01/16 – 10/31/16
Occurrence Span Code 74: 10/04/16 – 10/04/16
Occurrence Span Code 74: 10/20/16 – 10/24/16
Value Code 80 = 25
Value Code 81 = 6
Legacy Claim Coding:
10/01/16 – 10/03/16 (COS 71)
10/04/16 – 10/04/16 (COS 71 with BR Type)
10/05/16 – 10/19/16 (COS 71)
10/20/16 – 10/24/16 (COS 71 with BR Type)
10/25/16 – 10/31/16 (COS 71)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*314000000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-ICFSN2*4600***65:A:3**A*Y*Y~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*201510151900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189~
HI*BI:74:RD8:20161004-20161004*BI:74:RD8:20161020-20161024~
HI*BE:23:::500*80:::25*BE:81:::6~
```

NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
LX*1~
SV2*0110**4500*DA*25~
REF*6R*EI122215247135641-01~
LX*2~
SV2*0185**100*DA*6~
REF*6R*EI122215247135641-02~
SE*40*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE-ICFSN2	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0653
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
CHICAGO, IL 60614502		123456789	100116	103116

8 PATIENT NAME	9 PATIENT ADDRESS			
a	a 555 NORTH STREET			
b DOE, JOHN	b CHICAGO	c IL	d 60614502	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	101515	19	3	4		30													

CONDITION CODES

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a									74	100416	100416	74	102016	102416	
b															

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	23	500.00	80	25.00	81	6.00
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0110	ROOM - BOARD/ PVT		100116	25	4500.00		
2	0185	LOA/NURS HOME		100416	6	100.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	4600.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567893
A ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	

58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX: Z5189 | I6350 | 68

69 ADMIT DX: M6281 | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC	
	a	B3 314000000X
	b	
	c	
	d	

EXAMPLE ~ ICF3:
Skilled Nursing Facility billing claim for recipient residing in an intermediate care bed with a leave of absence day and TPL reported on claim.

Statement Period: 10/01/16 – 10/31/16
Occurrence Span Code 74: 10/05/16 – 10/5/16
Value Code 80 = 30
Value Code 81 = 1
Legacy Claim Coding:
10/01/16 – 10/04/16 (COS 71)
10/05/16 – 10/05/16 (COS 71 with BR Type)
10/06/16 – 10/31/16 (COS 71)

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ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*313M00000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*S*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-ICF3*4250***65:A:3**A*Y*Y~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*201609301900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350 ~
HI*ABF: Z5189~
HI*BI:74:RD8:20161005-20161005~
HI*BE:23:::500*80:::30*81:::1~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
```

SBR*P*18** HCSC-BCBS OF IL-STD A & B *****BC~
CAS*CO*45*3150.00***~
CAS*PR*2*50.00~
AMT*D*1050.00~
OI***Y***Y~
NM1*IL*1*DOE*JOHN****MI*011545209A~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
NM1*PR*2*HCSC-BCBS OF IL-STD A & B*****PI*30024~
N3*300 EAST RANDOLPH, 13TH FLOOR~
N4*CHICAGO*IL*60601~
DTP*573*D8*20161201~
REF*2U*00601~
LX*1~
SV2*0110**4150*DA*30~
REF*6R*EI122215247135642-01~
LX*2~
SV2*0182**100*DA*1~
REF*6R*EI122215247135642-02~
SE*53*0001~
GE*1*528986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE-ICF3	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0653
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH
CHICAGO, IL 60614502		123456789	100116	103116

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	093016	19	3	4		30													

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a									74	100516	100516				
b															

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	23	500.00	80	30.00	81	1.00
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0110	ROOM - BOARD/ PVT		100116	30	4150.00		
2	0182	LOA/PT CONV		100516	1	100.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	4250.00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567893
A	HCSC-BCBS OF IL-STD A&B	00601			1050.00		57 OTHER PRV ID	
B	ILLINOIS MEDICAID	37-1320188	Y	Y				
C								

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN	18	011545209A		
B	DOE, JOHN	18	011545209		
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX: Z5189 I6350 | 68

69 ADMIT DX: M6281 | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a	B3	313M00000X
	b		
	c		
	d		

EXAMPLE ~ ICF4:
Claim for Medicaid covered days prior to discharge to hospital.
Medicaid Primary
Statement Period: 10/01/16 – 10/15/16
Discharge Status Code = 02
Value Code 80 = 14
Legacy Claim Coding:
10/01/16 – 10/14/16 (COS 71)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*313M00000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE -ICF4*1400***65:A:1**A*Y*Y~
DTP*096*TM*1300~
DTP*434*RD8*20161001-20161015~
DTP*435*DT*201610011900~
CL1*3*4*02~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189 ~
HI*BE:23:::500*BE:80:::14~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X
LX*1~
SV2*0110**1400*DA*14~
REF*6R*EI122215247135643-02~
```

SE*37*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE -ICF4	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0651
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
CHICAGO, IL 60614502		123456789	100116	101516

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4	13	02													

CONDITION CODES

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	23	500.00	80	14.00		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0110	ROOM - BOARD/ PVT		100116	14	1400.00		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	1400.00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	ILLINOIS MEDICAID	37-1320188	Y	Y			1234567893	A
B							57 OTHER PRV ID	B
C								C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN	18	011545209		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX: Z5189 | I6350 | 68

69 ADMIT DX: M6281 | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81CC			
a	B3	313M00000X	
b			
c			
d			

EXAMPLE ~ ICF5:
Claim for Medicaid covered days prior to discharge due to death.
Medicaid Primary
Statement Period: 10/01/16 – 10/15/16
Discharge Status Code = 20
Value Code 80 = 15
Legacy Claim Coding:
10/01/16 – 10/15/16 (COS 71)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*313M00000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE –ICF5*1400***65:A:4**A*Y*Y~
DTP*096*TM*1300~
DTP*434*RD8*20161001-20161015~
DTP*435*DT*201609301900~
CL1*3*4*20~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189 ~
HI*BE:23:::500*BE:80:::15~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X
LX*1~
SV2*0110**1400*DA*15~
REF*6R*EI122215247135644-01~
```

SE*37*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL. #	EXAMPLE -ICF5	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0654
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
CHICAGO, IL 60614502		123456789	100116 / 101516	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	093016	19	3	4	13	20													

CONDITION CODES

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															
b															

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	23	500.00	80	15.00		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0110	ROOM - BOARD/ PVT		100116	15	1400.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	1400.00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567893
A	ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	
B								
C								

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN	18	011545209		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX										68
	Z5189	I6350								

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI				73
M6281										

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a	B3	313M00000X
	b		
	c		
	d		

EXAMPLE ~ ICF 6:
Claim for recipient in a Medicaid bed who has Medicare Advantage Plan (MAP) coverage on system but not in a Managed Care Program, with leave of absences on claim.

Statement Period: 10/01/16 – 10/31/16
Occurrence Span Code 74: 10/04/16 – 10/4/16 and 10/20/16 – 10/24/16
Discharge Status Code = 01
Value Code 80 = 24
Value Code 81 = 6
Legacy Claim Coding:
10/01/16 – 10/03/16 (COS 71)
10/04/16 – 10/04/16 (COS 71 with BR Type)
10/05/16 – 10/19/16 (COS 71)
10/20/16 – 10/24/16 (COS 71 with BR Type)
10/25/16 – 10/30/16 (COS 71)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*313M00000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-ICF6*3300***65:A:1**A*Y*Y~
DTP*96*TM*1400~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*20161001900~
CL1*3*4*01~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189~
HI*BI:74:RD8:20161004-20161004*BI:74:RD8:20161020-20161024~
```

HI*BE:23:::500*BE:80:::24*BE:81:::6~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
SBR*P*18** MOLINA4*****HM~
CAS*CO*45*1000.00***~
CAS*PR*2*50.00~
AMT*D*2150.00~
OI***Y***Y~
NM1*IL*1*DOE*JOHN****MI*011545209A~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
NM1*PR*2*MOLINA MEDICARE ADVANTAGE*****PI*30024~
N3*233 EAST PEORIA ROAD~
N4*CHICAGO*IL*60601~
DTP*573*D8*20161101~
REF*2U*92001~
LX*1~
SV2*0110**2700*DA*24~
REF*6R*EI122215247135645-01~
LX*2~
SV2*0182**100*DA*1~
REF*6R*EI122215247135645-02~
LX*3~
SV2*0185**500*DA*5~
REF*6R*EI122215247135645-03~
SE*57*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE - ICF6	4 TYPE OF BILL
ACME LTC TEST		3b. MED. REC. #	00712	0651
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
CHICAGO, IL 60614502		123456789	100116 / 103116	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4	13	01													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a								74	100416	100416	74	102016	102416	a
b														b

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	23	500.00	80	24.00	81	6.00
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0110	ROOM - BOARD/ PVT		100116	24	2700.00		
2	0182	LOA/PT CONV		100416	1	100.00		
3	0185	LOA/NURS HOME		102016	5	500.00		
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	3300.00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567893
A	MOLINA MEDICARE ADV	92001	Y	Y	2150.00		57	
B	ILLINOIS MEDICAID	37-1320188	Y	Y			OTHER	
C							PRV ID	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN	18	011545209A		
B	DOE, JOHN	18	011545209		
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX									68
	Z5189	I6350							

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI			73
M6281									

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a	B3	313M00000X
	b		
	c		
	d		

EXAMPLE ~ ICFDT7:
Claim for Developmental Training Services.
Statement Period: 10/01/16 – 10/31/16
Value Code 80 = 31
Legacy Claim Coding:
10/01/16 – 10/31/16 (COS 83)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*313M00000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-ICFDT7*1800***79:A:2**A*Y*Y~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*201610011900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189 ~
HI*BE:24:::481*BE:80:::31~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
LX*1~
SV2*0942**1800*DA*31~
REF*6R*EI122215247135646-01~
SE*35*0001~
GE*1*525986~
IEA*1*000525985~
```

1	2	3a PAT. CNTL #	EXAMPLE - ICFDT7	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0792
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
CHICAGO, IL 60614502		123456789	100116	103116

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4		30													

CONDITION CODES

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	24	481.00	80	31.00		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0942	EDUC/TRAINING		100116	31	1800.00		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	1800.00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	ILLINOIS MEDICAID	37-1320188	Y	Y			1234567893	A
B							57 OTHER PRV ID	B
C								C

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	DOE, JOHN	18	011545209			A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX: Z5189 | I6350 | 68

69 ADMIT DX: M6281 | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC	
	a	B3 313M00000X
	b	
	c	
	d	

EXAMPLE ~ ICFDT8:
Claim for Developmental Training Services for recipient who has dis-enrolled from Developmental Training Agency.
Statement Period: 10/01/16 – 10/15/16
Discharge Code = 70
Value Code 80 = 14
Legacy Claim Coding:
10/01/16 – 10/14/16 (COS 83)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*31300000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE-ICNFDT8*800***79:A:1**A*Y*Y~
DTP*096*TM*1400~
DTP*434*RD8*20161001-20161015~
DTP*435*DT*201610011900~
CL1*3*4*70~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189 ~
HI*BE:24:::1480*BE:80:::14~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
LX*1~
SV2*0942**800*DA*14~
REF*6R*EI122215247135647-01~
```

SE*36*0001~
GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE - ICFDT8	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0791
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
CHICAGO, IL 60614502		123456789	100116	101516

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4	14	70													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	24	1480.00	80	14.00		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0942	EDUC/TRAINING		100116	14	800.00		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	800.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567893
A ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	
B							
C							

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX									68
	Z5189	I6350							

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI			73
M6281									

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a	B3	313M00000X
	b		
	c		
	d		

EXAMPLE ~ ICFEC9:
Claim for recipient receiving enhanced care (vent).

Statement Period: 10/01/16 – 10/31/16
Value Code 80 = 31
Legacy Claim Coding:
10/01/16 – 10/31/16 (COS 38)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*314000000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE- ICFEC9*7000***65:A:2**A*Y*Y~
DTP*434*RD8*20161001-20161031~
DTP*435*DT*201610011900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189~
HI*BE:23:::500*BE:80:::31~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
LX*1~
SV2*0194**7000*DA*31~
REF*6R*EI122215247135648-01~
SE*36*0001~
GE*1*525986~
IEA*1*000525985~
```

1	2	3a PAT. CNTL. #	EXAMPLE - ICFEC9	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0652
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
CHICAGO, IL 60614502		123456789	100116 / 103116	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4		30													

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	23	500.00	80	31.00		
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0194	SUBACUTE/LEVELIV		100116	31	7000.00		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	7000.00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567893
A	ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	
B								
C								

	58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOE, JOHN	18	011545209		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX									68
	Z5189	I6350							

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI			73
M6281									

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

76 ATTENDING	NPI 1222222222	QUAL.
LAST JACKSON	FIRST IGOR	
77 OPERATING	NPI	QUAL.
LAST	FIRST	
78 OTHER	NPI	QUAL.
LAST	FIRST	
79 OTHER	NPI	QUAL.
LAST	FIRST	

80 REMARKS	81CC		
	a	B3	314000000X
	b		
	c		
	d		

EXAMPLE ~ ICFHOSPIC10:
Claim for recipient discharging to hospice.

Statement Period: 10/01/16 – 10/05/16
Value Code 80 = 4
Discharge Status Code = 51
Legacy Claim Coding:
10/01/16 – 10/04/16 (COS 71)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*314000000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE- ICFHOSPIC10*500***65:A:1**A*Y*Y~
DTP*096*TM*1400
DTP*434*RD8*20161001-20161005~
DTP*435*DT*201610011900~
CL1*3*4*51~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189~
HI*BE:23:::500*BE:80:::4~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
LX*1~
SV2*0110**500*DA*4~
REF*6R*EI122215247135649-01~
SE*37*0001~
```

GE*1*525986~
IEA*1*000525985~

1	2	3a PAT. CNTL #	EXAMPLE -ICFHOSPIC10	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0651
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
CHICAGO, IL 60614502		123456789	100116 / 100516	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 555 NORTH STREET
b DOE, JOHN	b CHICAGO c IL d 60614502 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	100116	19	3	4	14	51													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	23	500.00	80	4.00		
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0110	ROOM - BOARD/ PVT		100116	4	500.00		
2–22								
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	500.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567893
A ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	
B							
C							

58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX									68
Z5189	I6350								

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI			73
M6281									

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1222222222	QUAL
LAST JACKSON		FIRST IGOR
77 OPERATING	NPI	QUAL
LAST		FIRST
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

80 REMARKS	81CC		
	a	B3	314000000X
	b		
	c		
	d		

EXAMPLE ~ ICFHOSPIC11:
Claim for recipient after hospice election ends.

Statement Period: 10/24/16 – 10/31/16
Value Code 80 = 8
Legacy Claim Coding:
10/24/16 – 10/31/16 (COS 71)

```
ISA*00*          *00*          *ZZ*030230130      *ZZ*37-1320188INT     *161225*1635*^*00501*000525985*0*T*:~
GS*HC*ACME BILLING AGENT*37-2323232*20161225*1635*525986*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*A1CFA5C0-2222-484E-9999-08CEE*20161101*083756*CH~
NM1*41*2*ACME CORP*****46*36-9999999~
PER*IC*MOLLY SMITH*EM*MSMITH@ACMECORP.COM~
NM1*40*2*ILLINOIS MEDICAID*****46*37-1320188~
HL*1**20*1~
PRV*BI*PXC*314000000X~
NM1*85*2*ACME LTC TEST*****XX*1234567893 ~
N3*555 NORTH STREET~
N4* CHICAGO *IL*606141502~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*DOE*JOHN****MI*011545209~
N3*555 NORTH STREET ~
N4*CHICAGO*IL*606141502~
DMG*D8*19260929*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*201 S GRAND AVENUE E~
N4*SPRINGFIELD*IL*62763~
CLM*EXAMPLE- ICFHOSPIC11*800***65:A:2**A*Y*Y~
DTP*434*RD8*20161024-20161031~
DTP*435*DT*201610241900~
CL1*3*4*30~
REF*EA*00712~
REF*D9*122215247135643~
HI*ABK: M6281~
HI*ABJ: I6350~
HI*ABF: Z5189~
HI*BE:23:::500*BE:80:::8~
NM1*71*1*JACKSON*IGOR****XX*1222222222~
PRV*AT*PXC*207R00000X~
LX*1~
SV2*0110**800*DA*8~
REF*6R*EI122215247135650-01~
SE*36*0001~
GE*1*525986~
IEA*1*000525985~
```

1	2	3a PAT. CNTL #	EXAMPLE -ICFHOSPIC11	4 TYPE OF BILL
ACME LTC TEST		b. MED. REC. #	00712	0652
555 NORTH STREET		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
CHICAGO, IL 60614502		123456789	102416 / 103116	

8 PATIENT NAME	9 PATIENT ADDRESS			
a	a 555 NORTH STREET			
b DOE, JOHN	b CHICAGO	c IL	d 60614502	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
09291926	M	102416	19	3	4		30													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	23	500.00	80	8.00		
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0110	ROOM - BOARD/ PVT		102416	8	800.00		
2–22								
23	0001	PAGE 1 OF 1	CREATION DATE	110116	TOTALS	800.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567893
A ILLINOIS MEDICAID	37-1320188	Y	Y			57 OTHER PRV ID	
B							
C							

58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A DOE, JOHN	18	011545209		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX									68
	Z5189	I6350							

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI			73
	M6281								

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

76 ATTENDING	NPI 1222222222	QUAL	
LAST JACKSON		FIRST IGOR	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a	B3	314000000X
	b		
	c		
	d		