ILLINOIS DEPARTMENT OF Healthcare and Family Services

Long Term Care Service Billing Requirements and Coding

Revised: 09/26/16
Overview and Objectives of This Presentation:

- To provide an overview of basic billing rules

- To provide billing requirements and claim coding specifications for each provider type so submitted claims can be accepted and priced correctly.

- To provide coding examples for common billing scenarios.
The Department will accept claims in an American National Standard (ANS) X12 837I Health Care Claim (5010) file format or as a direct data entered (DDE) claim.
Business as Usual...

To be eligible for payment consideration all Long Term Care (LTC) claims submitted on an 837I must meet the same requirements as current Department generated LTC claims do. The Direct Billing of LTC services is strictly a billing process change.

- No changes are being made to provider or recipient eligibility policies related to payment of LTC services.
  - Claims received for a provider or recipient that is ineligible for payment of the billed services or billed service period submitted will be rejected. (Note: Recipient must be Medicaid eligible and have an LTC admit on system to be eligible for LTC payment.)

- No changes are being made to policies related to the requirements to bill other payers before submission of a claim for Medicaid reimbursement.
  - Claims received for a recipient who has a TPL, such as Blue Cross Blue Shield or any other commercial payer, and for which TPL is not reported on the submitted claim will be rejected.
  - Claims received for a recipient whose services are covered by a Managed Care Organization will be rejected.
  - Claims received for a recipient residing in a nursing facility (provider type 033) with Medicare Part A coverage that do not reflect a Medicare payment or do not show Medicare exhaust date or date active care coverage ended will be rejected.

- No changes are being made to the timely submittal requirements for payment consideration of LTC claims.
  - Claims received, as an initial or resubmitted claim following prior rejection, more than 180 days after the date of service or the date the admission transaction is completed by DHS caseworker will be rejected.
  - Claims after disposition by Medicare or its fiscal intermediary must be received by the Department no later than 24 months after the date of service.

- No changes are being made to the procedures for billing service periods prior to October 1, 2016. Only claims for LTC service periods beginning October 1, 2016 and after can be submitted electronically on the 837I.
  - LTC service periods prior to October 1, 2016 will be rejected if submitted on the 837I.
  - Paper UB-04 claims submitted for LTC services will not be accepted.
The combination of NPI, Taxonomy Codes and Type of Bill Facility Codes submitted on a claim provides critical information that allows the Department to properly price the received claim. Therefore, there will be strictly enforced edits to assure that appropriate codes are received on the claim.

- If the NPI used to submit an LTC claim is not a registered NPI in the NPPES system, or cannot be cross-walked to a unique HFS PIN, the claim will be rejected.

- If the Taxonomy Code used to submit an LTC claim is not an accepted Taxonomy for billing provider type, the claim will be rejected.

- If the Type of Bill Facility Code used to submit an LTC claim is not an accepted Type of Bill Facility Code for provider, the claim will be rejected.

Electronic claims submitted for LTC services must be for a single month of service.

- Claims that are submitted for more than one calendar month will be rejected.

- For IID facilities (Provider Type 29) claims only – Claims received out of sequence will not be rejected but cannot be priced until the preceding month’s claim has been processed. Prior claim information related to temporary absences and Medicare coverage will be reviewed for proper pricing of current claim.

Providers must bill services using the Revenue Codes, which identify specific accommodations, ancillary or unique billing calculations or arrangements. A list of all available Revenue Codes can be found in the NUBC UB–04 Official Data Specifications Manual. Most available revenue codes will be accepted on an LTC 837I claim but only certain codes will be used to price LTC claims.

- Claims received without Revenue Codes that can be priced will be rejected.

- Claims received with exceptional care Revenue Codes for which there is not approval on the system will be rejected.

- Claims submitted without leave of absence Revenue Codes and Occurrence Span Code, to cover the same days claimed as inpatient hospital stay, will be rejected.
The new LTC billing process has been designed utilizing the guidelines set forth by the Washington Publishing Company 837 Institutional Implementation Guidelines for the Health Insurance Portability and Accountability Act (HIPAA), version 005010X223 and the National Uniform Billing Committee’s (NUBC) data specifications, UB–04. However, in order for your submitted claims to be accepted and priced appropriately there are some state specific coding requirements.

Some of the state required codes vary by provider type and services being billed. The next few slides provide pricing codes needed for each provider and service type.
Supportive Living Program (SLP) – Provider Type 028

**Type of Bill**
Must be 89X – Special Facility Other – Outpatient Claim

**Type of Bill Frequency Code:**
1 – Admit Through Discharge
2 – Interim – First Claim
3 – Interim – Continuing Claim
4 – Interim – Last Claim
5 – Late Charge(s) Only (Informational)

**Taxonomy Codes:**
311500000X – Dementia Special Care = Legacy COS 086
310400000X – Assisted Living Facility = Legacy COS 087

**Revenue Codes:**
0240 – All Inclusive Ancillary, General Classification = Legacy COS 086 or 087 based on Taxonomy Code
0182 – Leave of Absence Days, Patient Convenience = Legacy BR codes 70 & 71
0183 – Leave of Absence Days, Therapeutic = Legacy BR codes 70 & 71
0185 – Leave of Absence Days, Hospitalization = Legacy BR codes 60 & 61

**Occurrence Span Codes and Dates:**
74 – Non-Covered Level of Care/Leave of Absence Dates

**Value Codes:**
80 – Covered Days
81 – Non-Covered Days
23 – Recurring Monthly Income (Patient Credit Amount)

**Leave of Absence Days (LOA) or Bed Reserve (BR) Days:**
LOA days will be reported with LOA Revenue Codes and must have a corresponding non-covered occurrence span code 74 with the appropriate LOA dates even though some bed reserve days may be payable. The total of “non-covered” days must also be reflected with a value code of 81.

LOA days 1 – 30 in FY – Payable at 100% of facility daily Per Diem (Legacy BR codes 60 and 70)
LOA days 31 or over in FY – Non-payable (Legacy BR codes 61 and 71)

The count of LOA days reported on prior claims will be utilized to determine if the LOA days reported on each submitted claim for services within the fiscal year are payable or non-payable.
Intermediate Care Facility for Individuals with Intellectual Disabilities (IID) – Provider Type 029

**Type of Bill**
066X Intermediate Care
079X Clinic – Other (Developmental Training) – Outpatient Claim

**Type of Bill Frequency Code:**
1 – Admit Through Discharge
2 – Interim – First Claim*
3 – Interim – Continuing Claim
4 – Interim – Last Claim
5 – Late Charge(s) Only (Informational)

* Type of Bill Frequency Code 2–First Claim, should only be used for a claim submitted with an statement begin date equal to the admission date on the HFS system. Do not use for claims submitted for service period after a re-admission from a LOA.

**Taxonomy Codes:**
315P00000X – ICF Mentally Retarded with Bill Type 066X
Legacy COS 073
Legacy COS 038 – (Revenue code 0190 and approved Exceptional Care coverage)

315P00000X – ICF Mentally Retarded with Bill Type 079X
Legacy COS 082 – (Revenue Code 0942 and approved DT enrollment)

3140N1450X – Nursing Care – Pediatric with Bill Type 066X
Legacy COS 074
Legacy COS 038 – (Revenue code 0190 and approved Exceptional Care coverage)

3140N1450X – Nursing Care – Pediatric with Bill Type 079X
Legacy COS 082 – (Revenue Code 0942 and approved DT enrollment)

320600000X – Residential Treatment Facility, Mental Retardation and/or Dev. Disabilities with Bill Type 065X or 066X
Legacy COS 076
Legacy COS 038 – (Revenue code 0190 and approved Exceptional Care coverage)

320600000X – Residential Treatment Facility, Mental Retardation and/or Dev. Disabilities with Bill Type 079X
Legacy COS 082 – (Revenue Code 0942 and approved DT enrollment)

**Revenue Codes:**
0110 – 0160 – Priced as General Room & Board = Legacy COS 073, 074 or 076 based on Taxonomy code
0182 – Leave of Absence Days, Patient Convenience = Legacy BR codes 21, 22 & 24
0183 – Leave of Absence Days, Therapeutic = Legacy BR codes 21, 22 & 24
0185 – Leave of Absence Days, Hospitalization = Legacy BR codes 12, 13, 14 & 16
0190 – Sub acute Care – General Classification = Legacy COS 038
0942 – Education/Training = Legacy COS 082
Occurrence Span Codes and Dates:
74 – Non-Covered Level of Care/Leave of Absence Dates

Value Codes:
80 – Covered Days
81 – Non-Covered Days
23 – Recurring Monthly Income (Patient Credit)
24 – Medicaid Rate Code (DT Agency Code)

Leave of Absence Days (LOA) or Bed Reserve (BR) Days:
LOA days will be reported with LOA Revenue Codes and must have a corresponding non- covered occurrence span code 74 with the appropriate LOA dates even though some bed reserve days may be payable. The total of “non-covered” days must also be reflected with value code 81.

LOA reported as Revenue Codes 0182 and 0183 will be considered Therapeutic bed reserve days.
Days 1 – 10 in FY – Payable at 100% of facility daily Per Diem (Legacy BR code 22)
Days exceeding 10 in a FY – Payable at 75% of facility daily Per Diem (Legacy BR code 24)

LOA reported as Revenue Code 0185 will be considered Hospitalization bed reserve days.
For recipients under 21 years of age
Days 1 – 10 of a consecutive Hospital stay – Payable at 100% of facility daily Per Diem (Legacy BR code 12)
Days 11 – 30 of a consecutive Hospital stay – Payable at 75% of facility daily Per Diem (Legacy BR code 14)
Days 31 – 45 of a consecutive Hospital stay – Payable at 50% of facility daily Per Diem (Legacy BR code 16)
Days 46 – on of a consecutive Hospital stay – Non-Payable (Legacy BR code 13)

The count of LOA days reported on prior claims will be utilized to determine if the LOA days reported on each submitted claim for services within the fiscal year are payable or non-payable.

Claims must submitted and be will be adjudicated in sequence.
Nursing Facilities (NF) – Provider Type 033

**Type of Bill**
021X Skilled Nursing Inpatient (Including Medicare Part A)
022X Skilled Nursing Facilities (Including Medicare Part B)
065X Intermediate Care
079X Clinic–Other (Developmental Training) – Outpatient Claim

**Type of Bill Frequency Code:**
1 – Admit Through Discharge
2 – Interim – First Claim
3 – Interim – Continuing Claim
4 – Interim – Last Claim
5 – Late Charge(s) Only (Informational)

**Revenue Codes:**
0110 – 0160 – Priced as General Room & Board = Legacy COS 065, 070, 071 or 072 based on Taxonomy Code & Bill Type
0182 – Leave of Absence Days, Patient Convenience = Legacy BR code 21
0183 – Leave of Absence Days, Therapeutic = Legacy BR code 21
0185 – Leave of Absence Days, Hospitalization = Legacy BR code 11
0191 – Sub acute Care Level I = Legacy COS 038 (TBI I )
0192 – Sub acute Care Level II = Legacy COS 038 (TBI II)
0193 – Sub acute Care Level III = Legacy COS 038 (TBI III)
0194 – Sub acute Care Level IV = Legacy COS 038 (Vent )
0942 – Education/Training = Legacy COS 082
0022 – Skilled Nursing Facility – PPS (RUG)

**NOTE:** A Rug Score is not required to be reported on a claim, but will be accepted as a Revenue Code 0022 with a 5 digit Rug Score in Procedure Code field, the total number of days and a zero charge. If a Rug Score is sent the associated assessment date should be sent as a Occurrence Code 50.
**Taxonomy Codes:**

- **314000000X – Skilled Nursing Facility with Bill Types 021X**
  - Legacy COS 065 – Priced as zero when crossover shows full Medicare coverage
  - Legacy COS 072 – Medicaid Payable over Medicare Payable amount

- **314000000X – Skilled Nursing Facility with Bill Types 021X or 022X Showing Medicare Benefit Exhaust/End/Denied**
  - Legacy COS 070
  - Legacy COS 038 – (Revenue code 0191 – 0194 and approved Exceptional Care coverage)

- **314000000X – Skilled Nursing Facility with Bill Type 079X**
  - Legacy COS 083 – (Revenue Code 0942 and approved DT enrollment)

- **313M00000X – Nursing Facility/Intermediate Care Facility with Bill Types 065X**
  - Legacy COS 071
  - Legacy COS 038 – (Revenue code 0191 – 0194 and approved Exceptional Care coverage)

- **313M00000X – Nursing Facility/Intermediate Care Facility with Bill Type 079X**
  - Legacy COS 083 – (Revenue Code 0942 and approved DT enrollment)

- **282N00000X – General Acute Care Hospital (LTC Wing) with Bill Types 21X**
  - Legacy COS 065 – Priced as zero when crossover shows full Medicare coverage
  - Legacy COS 072 – Medicaid Payable over Medicare Payable amount

- **282N00000X – General Acute Care Hospital (LTC Wing) with Bill Types 021X or 022X showing Medicare Benefit Exhaust/End/Denied**
  - Legacy COS 070
  - Legacy COS 038 – (Revenue code 0191 – 0194 and approved Exceptional Care coverage)

- **282N00000X – General Acute Care Hospital (LTC Wing) with Bill Types 065X**
  - Legacy COS 071
  - Legacy COS 038 – (Revenue code 0191 – 0194 and approved Exceptional Care coverage)
**Occurrence Code**
A2 – Effective Date of Policy (First Day of Medicaid)
A3 – Benefits Exhausted (Last Day of Medicare)
B3 – Benefits Exhausted – Payer B (Last Day of Medicare)
22 – Date Active Care Ended (Last Day of Medicare)
25 – Date Benefits Terminated by Primary Payer (First Day of Medicaid)
50 – Assessment Date

**Occurrence Span Codes and Dates:**
70 – Qualifying Stay Dates for SNF
74 – Non-Covered Level of Care/Leave of Absence Dates

**Value Codes:**
80 – Covered Days
81 – Non-Covered Days
82 – Coinsurance Days
23 – Recurring Monthly Income (Patient Credit Amount)
24 – Medicaid Rate Code (DT Agency Code)

**Leave of Absence Days (LOA) or Bed Reserve (BR) Days:**
LOA days will be reported with LOA Revenue Codes and must have a corresponding non-covered occurrence span code 74 with the appropriate LOA dates. The total of “non-covered” days must also be reflected with value code 81.

LOA reported as Revenue Codes 0182 and 0183 will be considered Therapeutic bed reserve days.
All are non-payable (Legacy BR code 21)

LOA reported as Revenue Code 0185 will be considered Hospitalization bed reserve days.
All are non-payable (Legacy BR code 11)
Medicare Crossover Claims

Recipients with Medicare Part A coverage must be billed to Medicare for any covered service prior to billing Medicaid. Claims submitted to Medicare will crossover to Medicaid through a fiscal intermediary. To assure proper pricing of Medicare crossover claims, LTC providers should submit LTC claims for a single calendar month of service to Medicare for dually eligible recipients.

The Department’s policy regarding payment for Medicare Coinsurance days for Medicaid eligible persons is not changing. Medicare coinsurance paid by the Department, if any, will still be based on the amount that Medicare paid for the specific resident’s care. Medicare Coinsurance days payable by Medicaid will be derived from received crossover claims information by using Value Codes and accommodation days.

In the event that a Medicare claim does not successfully crossover for Medicaid pricing the provider may submit a claim with Medicare coverage directly to Illinois Medicaid for payment consideration.
Claims With Medicare Coverage Submitted Directly to Illinois Medicaid

Claims submitted to Medicare for reporting purposes only or for a benefit exhaust period are not sent to Medicaid through the fiscal intermediary. In addition claims sent to Medicare may not successfully crossover. These claims will be rejected back to the provider. Some of the reasons a crossover claim may reject are:

- Medicaid system does not have a LTC admission for recipient, provider or date of service.
- Medicaid system does not have Medicaid eligibility for the recipient or the date of service.
- Medicare claim received has a statement period that crosses calendar months;
  - i.e. 07/05/16 – 08/19/16

Claims for Medicare covered service periods that do not crossover to Illinois Medicaid may be sent directly to Medicaid for payment consideration. Claims with Medicare coverage billed directly to Medicaid must show Medicare as primary payer and Medicare Coinsurance days as Value code 82 with a TPL payment amount using the Medicare TPL code 909. The Medicare days payable by Medicaid will be derived from received claim information by using Value Codes and accommodation days as follows:

- Calculation of accommodation days:
  - The total accommodation days will be based on service from, service through dates and Type of Bill Frequency.
    - If Type of Bill Frequency Code is 2 or 3 will include service through date.
    - If Type of Bill Frequency Code is 1 or 4 will not include the date of discharge unless the patient discharge status is 20.

- Calculation of Medicaid Covered Days and Medicare Covered Days for Legacy COS Coding and Pricing:
  - Value Code 80 – Covered Days = Full and Coinsurance Medicare Covered days
  - Value Code 81 – Non-Covered Days = Medicaid days and LOA days
  - Value Code 82 – Coinsurance Medicare Covered

  - If Value Code 80 = Value Code 82, then the days are all Coinsurance days. All Coinsurance days COS 072.
  - If Value Code 80 > Value Code 82 and no Medicare Coverage end date is given HFS will assume full Medicare coverage service beginning with Service From Date and will apply Coinsurance days to the end of statement period.
    - Value Code 80 amount – Value Code 82 amount = Full Covered Medicare Days (COS 065) starting from Statement From Date.
  - If Value Code 80 > Value Code 82 and the date Medicare coverage ended is present on the claim HFS will identify and price the coverage as follows:
    - The Statement From Date through the Medicare coverage end date will be identified as Medicare Covered Days.
    - The Medicare Covered Day – Coinsurance Days (Value Code 82) = Full Covered Medicare Days (COS 065) starting from Statement From Date.
    - The Days reported as Coinsurance (Value Code 82) (COS 072) will be applied beginning with the first date not determined to be Medicare Full Coverage.
    - If there are Leave of Absence days reported for date(s) within the Medicare Covered period they should be included in non–covered days reported in Value Code 81 and will be coded as non–payable bed reserves.

  - If Value Code 81 is reported and there are no Leave of Absence days all days after the Medicare Coverage End date will be considered Medicaid covered days (COS 070)
  - If Value Code 81 > or = the Total Leave of Absence all days reported in the Occurrence Span 74 date(s) will be coded as non–payable bed reserve days. All other days after the Medicare Coverage End date will be considered Medicaid covered days (COS 070).

See Claim Example #5
Type of Bill
065X Intermediate Care

Taxonomy Code:
310500000X – Intermediate Care Facility, Mental Illness with Bill Types 065X
Legacy COS 071

Type of Bill Frequency Code:
1 – Admit Through Discharge
2 – Interim – First Claim
3 – Interim – Continuing Claim
4 – Interim – Last Claim
5 – Late Charge(s) Only (Informational)

Revenue Codes:
0110 – 0160 – Priced as General Room & Board = Legacy COS 071
0182 – Leave of Absence Days, Patient Convenience = Legacy BR code 21
0183 – Leave of Absence Days Therapeutic = Legacy BR code 21
0185 – Leave of Absence Days Hospitalization = Legacy BR code 11

Occurrence Span Codes and Dates:
74 – Non-covered Level of Care/Leave of Absence Dates

Value Codes:
80 – Covered Days
81 – Non-covered Days
23 – Recurring Monthly Income (Patient Credit Amount)
24 – Medicaid Rate Code (DT Agency Code)

Leave of Absence Days (LOA) or Bed Reserve (BR) Days:
LOA days will be reported with LOA Revenue Codes and must have a corresponding non-covered
occurrence span code 74 with the appropriate LOA dates. The total of “non-covered” days must also be
reflected with a value code of 81.
Patient Credit

- Providers will continue to submit income changes and review patient credit amounts electronically through the EDI LTC links.

- The amount of patient credit applied to a claim will be based on the amount of patient credit entered into the LTC patient credit segments by the Department of Human Services (DHS) caseworker.

- Patient credit amounts should be reported as a Value Code 23 – Recurring Monthly Income on submitted claim.

- Upon implementation of the new LTC billing process, the application of the monthly patient credit amount applied to the fee-for-service LTC or Hospice claims will be processed on a first-come first-serve basis until the entire patient credit amount has been applied for the month. If a portion of the patient credit is used on the first claim received (either hospice or LTC) the remaining balance will be applied to the second claim.
Third Party Liability (TPL)

- Third Party Liability (TPL) payments will be allowed as a reduction from payable charges submitted on the LTC claim as “Other Payer”. Providers may refer to the “Source Code” field found in the TPL section of the MEDI eligibility verification for a recipient’s three-digit TPL code.

- If the recipient has a TPL such as Blue Cross Blue Shield or any other commercial payer and TPL is not reported on the submitted claim, the claim will not be rejected. The Department will continue to seek recovery through the current collection process.

- If the recipient has Hospital Insurance Benefits (HIB) or Qualified Medicare Beneficiary (QMB), the submitted claim must reflect Medicare as the primary payer even if the benefit has been exhausted.

- If the recipient has a Medicare Advantage plan and TPL is not reported on the submitted claim using the assigned TPL code of 920, the claim will be rejected.

- If the claim is Medicaid only or has a TPL other than Medicare, use Value Code 80 for the covered days and Value Code 81 for non-covered days. Covered days must equal the covered accommodation days on the claim.

- Prior payment amounts should be reported as claim level adjustments. Do not send any line level adjustment segments.
Hospice Services

NOTE: The following requirements are not applicable to Supportive Living Program providers.

- Recipients who have elected hospice services and are receiving the hospice services in the facility should be reported as Type of Bill Frequency 1 or 4 showing the patient is discharged with a discharge status code of 51 – Discharged to Hospice Medical Facility (Certified) providing Hospice Level of Care.

- Providers should not submit a discharge transaction through the EDI LTC links unless the resident is discharged into a community based hospice program, then a full discharge from the facility should be sent by submitting a discharge transaction through the EDI LTC links. Claims with a bill frequency of “1” or “4” should show a discharge status code of 50 – Hospice Home or discharge status code of 01.

- If hospice election ends and recipient is still a resident of the facility the LTC facility may resume billing for services. The first claim submitted after a hospice covered period should be billed as an Interim-First Claim, Type of Bill Frequency 2. Note that the statement from date and the admit date of the claim must match and be the first day not covered by hospice election.
NOTE: Providers are still required to report discharges to HFS by submitting a discharge transaction through the EDI LTC links.

- Discharge Status or Patient Status must also be reported on each claim, even if recipient is still a resident. A complete list of Patient Discharge Status Codes are available in the NUBC UB–04 Official Data Specifications Manual.

- HFS will continue to make payment to the facility for a resident’s date of death only when the individual is considered a resident of the facility on the date of death. For a payment for date of death the claim must reflect a Discharge Status Code of 20.
Currently HFS creates DT claims based off the recipient and provider eligibility as well as the DT enrollment information. Beginning with October 1, 2016 services, LTC providers will also have to submit 837I claims for payment of their contracted DT services. The current processes related to DT claim creation, payment and adjustments will continue for dates of service prior to October 1, 2016.

No changes are being made to program requirements or the process by which a LTC provider reports a recipient’s enrollment into or discharge from a DT agency to Medicaid. LTC providers will still be required to submit this information to DHS on an Enrollment/Disenrollment Form (IL 444-2768).

**Billing Requirements for DT Services Beginning October 1, 2016**

- DT services beginning October 1, 2016 will be billed by the LTC facility on a claim separate from their claim for room and board using Type of Bill 079X with a Revenue Code of 0942.

- Claims submitted for DT services should be a monthly claim and will not be allowed to cross calendar months.

- Only one DT agency can be billed per claim.

- Claims submitted for DT services will contain the Department assigned four (4) digit DT agency code indicating which DT agency provided the DT services to the recipient as a Value Code 24. The actual DT agency code will be reported in the dollar field of the Value Amount data element. Although, the DDE results screen will display all Associated Amounts for Value Codes as monetary amounts the internal programming will recognize the amount as a agency code when Value Code 24 is used.

  - **Example:** DT Agency Code 0555 should be reported as a whole number with decimal point entered at the end 555.

    Value Code 24 Value Amount $555.00

- Received claims for DT services will be interrogated against recipient and provider eligibility, as well as, the DT enrollment information segments on the RDB for payment determination. If the received claim is for a service period not completely covered by a corresponding DT enrollment segment for the provider and recipient combination, the claim will be rejected back to the provider. If claim is not for a full month of service the following criteria should be met based on Bill Frequency Code or claim will be rejected back to provider.

  - Bill Frequency Code 1 – The claim begin date should correspond to the enrollment segment begin date and end date should equal the enrollment segment end date.
  - Bill Frequency Code 2 – The claim begin date should correspond to the enrollment segment begin date or the first day of the month.
  - Bill Frequency Code 3 – The claim begin and end date must fall within the enrollment segment begin and end dates.
  - Bill Frequency Code 4 – The claim end date should correspond to the enrollment segment end date.
Ready for some claim Examples?
The Claim has been submitted. Date: 05/17/2016 Time: 15:27 Confirmation Number: 000041680
Submitter Tax Id: 123456789003 Submitter Name: ACME LTC TEST
Submitter Contact Name: JANE DOE
Submitter Contact Email Address: JANED@GMAIL.COM
Total Net Amount Billed: 3100.00 Total TPL Payments: 0.00

Patient/Subscriber Information
Recipient ID Number (RIN): 015574619 Recipient Name: TEST THIRTYFIVE Date of Birth: 11/08/1921 Gender: Female
Recipient Address:
Address Line 1: 201 S GRAND Address Line 2: City: SPRINGFIELD State: IL Zip Code: 62763

(Billing) Provider Information
Provider: 123456789003 NPI: 1234567893 Provider Taxonomy Code: 310400000X

Claim Information
Patient Account Number: 121212121212121 Type of Bill Frequency Code: 2 – Interim First Claim Delay Reason Code:
Total Claim Charge Amount: $3100.00 Type of Bill Facility Code: 89 Supportive Living Priority (Type) of Admission or Visit: 3 – Elective Point of Origin for Admission or Visit: 9 – Info Not Avail Patient Discharge Status: 30 Prior Authorization Number: Original DCN: Medical Record Number:
Admission/Start of Care Date: 07/01/2016 Admission Hour: Discharge Hour:
Statement From Date: 07/01/2016 Statement Through Date: 07/31/2016

EPSDT Screening
Was this patient referred for services as a result of an EPSDT screening? No

Attachment Information
Type of Attachment: Attachment Control Number:
Principal Diagnosis and Procedure Codes
Principal Diagnosis: Z789 POA Indicator: Admitting Diagnosis: E Diagnosis: POA Indicator: Y
Value, Condition, and Occurrence Code Information
Accident State:
Occurrence Span Code: From Date: To Date:
Occurrence Code: Occurrence Date:
Value Code: 80 Associated Amount: $31.00
23 Associated Amount: $500.00
Condition Codes:
Physician Information Attending Physician Information
Attending Provider Name: John Smith Attending Provider NPI: 1316099999

Claim TPL Information
Claim TPL Line 0
Other Insured Information
Other Insured Name: ID: Claim Filing Code:
Other Payer Information
Other Payer Name: Other Payer Identifier:
TPL Code: TPL Status Code: Payer Paid Amount/ TPL Amount: Deductible: Coinsurance: CoPayment:

Adjudication or Payment Date:
Service Line Information
Service Line 1
Revenue Code: 0240
Unit Code: DA–Days Unit Count: 31 Line Item Charge Amount: $3100.00
Denied or Non–Covered Charge Amount:
Service From Date: 07/01/2016

Note: Reported Taxonomy and Revenue Code Drive the Legacy COS that will be used to price submitted claim and reported back to provider on paper remittance advice.
The Claim has been submitted. Date: 05/17/16 Time: 18:24 Confirmation Number: 000041681
Submitter Tax Id: 123456789003 Submitter Name: ACME LTC TEST
Submitter Contact Name: JANE DOE
Submitter Contact E-mail Address: JANED@GMAIL.COM
Total Net Amount Billed: 3100.00 Total TPL Payments: 0.00

Patient/Subscriber Information
Recipient ID Number (RIN): 015574619 Recipient Name: TEST THIRTYFIVE Date of Birth: 11/08/1921
Gender: Female
Recipient Address:
Address Line 1: 201 S GRAND Address Line 2: City: SPRINGFIELD State: IL Zip Code: 62763

(Billing) Provider Information
Provider: 123456789003 NPI: 1234567893 Provider Taxonomy Code: 310400000X

Claim Information
Patient Account Number: 121212121212 Type of Bill Frequency Code: 3 – Interim Continuing Claim
Delay Reason Code:
Total Claim Charge Amount: $3100.00 Type of Bill Facility Code: 89 Supportive Living Priority
(Type) of Admission or Visit: 3 – Elective Point of Origin for Admission or Visit: 9 – Info Not Avail
Patient Discharge Status: 30 Prior Authorization Number: Original DCN: Medical Record Number:
Admission/Start of Care Date: Admission Hour: Discharge Hour:
Statement From Date: 07/01/2016 Statement Through Date: 07/31/2016

EPSDT Screening
Was this patient referred for services as a result of an EPSDT screening? No

Attachment Information
Type of Attachment: Attachment Control Number:
Principal Diagnosis and Procedure Codes
Principal Diagnosis: Z789 POA Indicator: Admitting Diagnosis: E Diagnosis: POA Indicator: Y

Value, Condition, and Occurrence Code Information
Accident State:
Occurrence Span Code: 74 From Date: 07/01/16 To Date: 07/02/2016
74 From Date: 07/15/16 To Date: 07/15/2016
Occurrence Code: Occurrence Date:
Value Code: 80 Associated Amount: $28.00
81 Associated Amount: $3.00
23 Associated Amount $500.00

Condition Codes:
Physician Information Attending Physician Information
Attending Provider Name: John Smith Attending Provider NPI: 13160999999

Claim TPL Information
Claim TPL Line 0
Other Insured Information
Other Insured Name: ID: Claim Filing Code:
Other Payer Information
Other Payer Name: Other Payer Identifier:
TPL Code: TPL Status Code: Payer Paid Amount/ TPL Amount: Deductible: Coinsurance: CoPayment:
Adjudication or Payment Date:

Claim Continued on Next Slide
Service Line Information

Service Line 1
Revenue Code: 0182
Unit Code: DA-Days  Unit Count: 2  Line Item Charge Amount: $200.00
Denied or Non-Covered Charge Amount: 
Service From Date: 07/01/2016

Service Line 2
Revenue Code: 0185
Unit Code: DA-Days  Unit Count: 1  Line Item Charge Amount: $100.00
Denied or Non-Covered Charge Amount: 
Service From Date: 07/15/2016

Service Line 3
Revenue Code: 0240
Unit Code: DA-Days  Unit Count: 28  Line Item Charge Amount: $2800.00
Denied or Non-Covered Charge Amount: 
Service From Date: 07/03/2016

Note:

➢ The Line Item Charge Amount entered should reflect facility’s charges even if the leave of absence days will be non-payable by HFS.

➢ Claims must balance so Charges minus TPL deductions should equal the Total Amount Billed.

➢ The Unit Count should be reported in days and the total number of days in Service Lines must equal the number of days in Statement From and Statement Through dates.

➢ The total reported as Value Code 81 – Non-Covered should be the total amount reported as non-covered days in Service Lines.
The Claim has been submitted. Date: 05/18/16 Time: 12:03 Confirmation Number: 000041701
Submitter Tax Id: 12345678903 Submitter Name: ACME LTC TEST
Submitter Contact Name: JANE DOE
Submitter Contact E-mail Address: JANED@GMAIL.COM
Total Net Amount Billed: 2100.00 Total TPL Payments: 1000.00

Patient/Subscriber Information
Recipient ID Number (RIN): 015574619 Recipient Name: TEST THIRTYFIVE Date of Birth: 11/08/1921
Gender: Female
Recipient Address:
Address Line 1: 201 S GRAND Address Line 2: City: SPRINGFIELD State: IL Zip Code: 62763

(Billing) Provider Information
Provider: 12345678903 NPI: 1234567893 Provider Taxonomy Code: 315P00000X

Claim Information
Patient Account Number: 121212121212 Type of Bill Frequency Code: 3 - Interim Continuing Claim
Delay Reason Code:
Total Claim Charge Amount: $3100.00 Type of Bill Facility Code: 66 Intermediate Care/Institution for Intellectual Disabled

(Type) of Admission or Visit: 3 - Elective Point of Origin for Admission or Visit: 9 - Info Not Avail
Patient Discharge Status: 30 Prior Authorization Number: Original DCN: Medical Record Number:
Admission/Start of Care Date: Admission Hour: Discharge Hour:
Statement From Date: 10/01/2016 Statement Through Date: 10/31/2016

EPSDT Screening
Was this patient referred for services as a result of an EPSDT screening? No

Attachment Information
Type of Attachment: Attachment Control Number:

Principal Diagnosis and Procedure Codes
Principal Diagnosis: Z789 POA Indicator: Admitting Diagnosis: E Diagnosis: POA Indicator: Y

Value, Condition, and Occurrence Code Information
Accident State:
Occurrence Span Code: From Date: To Date:
Occurrence Code: Occurrence Date:
Value Code: 80 Associated Amount: $31.00
23 Associated Amount $500.00

Condition Codes:

Physician Information Attending Physician Information
Attending Provider Name: John Smith Attending Provider NPI: 1316099999

Claim TPL Information
Claim TPL Line 1

Other Insured Information
Other Insured Name: Test Thirtyfive ID: DD222222 Claim Filing Code: CI- Commercial Insurance

Other Payer Information
Other Payer Name: ABC Insurance Co Other Payer Identifier: 255655555
TPL Code: 222 TPL Status Code: 01 - TPL Adj Code: Payer Paid Amount/ TPL Amount: $1000.00
Deductible: $0.00 Coinsurance: $0.00 CoPayment: $0.00

Adjudication or Payment Date: 11/01/2016

Claim Continued on Next Slide
**Service Line Information**

**Service Line 1**

**Revenue Code:** 0110

**Unit Code:** DA-Days  **Unit Count:** 31  **Line Item Charge Amount:** $3100.00

**Denied or Non-Covered Charge Amount:**

**Service From Date:** 10/01/2016
The Claim has been submitted. Date: 05/18/16  Time: 11:04  Confirmation Number: 000041696
Submitter Tax Id: 123456789003  Submitter Name: ACME LTC TEST
Submitter Contact Name: JANE DOE
Submitter Contact E-mail Address: JANED@GMAIL.COM
Total Net Amount Billed: 5000.00  Total TPL Payments: 500.00

<table>
<thead>
<tr>
<th><strong>Patient/Subscriber Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recipient ID Number (RIN):</strong> 015574619  <strong>Recipient Name:</strong> TEST THIRTYFIVE  <strong>Date of Birth:</strong> 11/08/1921</td>
</tr>
<tr>
<td><strong>Gender:</strong> Female</td>
</tr>
<tr>
<td><strong>Recipient Address:</strong> Address Line 1: 201 S GRAND  Address Line 2: City: SPRINGFIELD  State: IL  Zip Code: 62763</td>
</tr>
</tbody>
</table>

(Billing) Provider Information

Provider: 123456789003  NPI: 1234567893  Provider Taxonomy Code: 3140N1450X

Claim Information

Patient Account Number: 1212121212  Type of Bill Frequency Code: 3 - Interim Continuing Claim
Delay Reason Code: 
Total Claim Charge Amount: $5500.00  Type of Bill Facility Code: 66 Intermediate Care/Institution for Intellectual Disabled

(Type) of Admission or Visit: 3 - Elective  Point of Origin for Admission or Visit: 9 - Info Not Avail
Patient Discharge Status: 30  Prior Authorization Number:  Original DCN:  Medical Record Number: 
Admission/Start of Care Date: 10/01/2016  Admission Hour:  Discharge Hour:  
Statement From Date: 10/01/2016  Statement Through Date: 10/31/2016

EPSDT Screening

Was this patient referred for services as a result of an EPSDT screening?  No

Attachment Information

Type of Attachment:  Attachment Control Number: 
Principal Diagnosis and Procedure Codes

Principal Diagnosis: Z789  POA Indicator: Admitting Diagnosis: E Diagnosis: POA Indicator: Y
Value, Condition, and Occurrence Code Information

Accident State: 
Occurrence Span Code: From Date:  To Date:  
Occurrence Code:  Occurrence Date:  
Value Code: 80  Associated Amount: $31.00  23  Associated Amount $500.00

Condition Codes:  
Physician Information Attending Physician Information

Attending Provider Name: John Smith  Attending Provider NPI: 13160999999

Claim TPL Information

Claim TPL Line 1 
Other Insured Information

Other Insured Name: Test Thirtyfive  ID: DD222222  Claim Filing Code: CI- Commercial Insurance

Other Payer Information

Other Payer Name: ABC Insurance Co  Other Payer Identifier: 645987DD  TPL Code: 222  TPL Status Code: 01 - TPL Adju  Payer Paid Amount/ TPL Amount: $500.00  Deductible: $0.00  Coinsurance: $0.00  CoPayment: $0.00

Adjudication or Payment Date: 11/01/2016

Claim Continued on Next Slide
Intermediate Care Facility for the Intellectually Disabled (IID) – Provider Type 029
Intermediate Care (COS 073) and Exceptional Care (COS 038) and TPL
EXAMPLE: 4 cont.

**Service Line Information**

**Service Line 1**
- Revenue Code: 0110
- **Unit Code:** DA-Days  **Unit Count:** 5  **Line Item Charge Amount:** $500.00
- Denied or Non-Covered Charge Amount:
- **Service From Date:** 10/01/2016

**Service Line 2**
- Revenue Code: 0190
- **Unit Code:** DA-Days  **Unit Count:** 26  **Line Item Charge Amount:** $5000.00
- Denied or Non-Covered Charge Amount:
- **Service From Date:** 10/06/2016
The Claim has been submitted. Date: 05/18/16 Time: 17:30 Confirmation Number: 201605201302
Submitter Tax Id: 12345678903 Submitter Name: ACME LTC TEST
Submitter Contact Name: JANE DOE
Submitter Contact E-mail Address: JANED@GMAIL.COM
Total Net Amount Billed: -27400.00 Total TPL Payments: 30500.00

Recipient ID Number (RIN): 015574619 Recipient Name: TEST THIRTYFIVE Date of Birth: 11/08/1921
Gender: Female
Recipient Address:
Address Line 1: 201 S GRAND Address Line 2: City: SPRINGFIELD State: IL Zip Code: 62763

Provider: 12345678903 NPI: 1234567893 Provider Taxonomy Code: 3140N1450X

Patient Account Number: 1212121212 Type of Bill Frequency Code: 3 - Interim Continuing Claim
Delay Reason Code:
Total Claim Charge Amount: $100.00 Type of Bill Facility Code: 21 Skilled Nursing (including Medicare Part A
(Type) of Admission or Visit: 3 - Elective Point of Origin for Admission or Visit: 9 - Info Not Avail
Patient Discharge Status: 30 Prior Authorization Number: Original DCN: Medical Record Number:

Statement From Date: 07/01/2016 Statement Through Date: 07/31/2016

Was this patient referred for services as a result of an EPSDT screening? No

Accident State:
Occurrence Span Code: 74 From Date: 07/06/16 To Date: 07/06/16
74 From Date: 07/18/16 To Date: 07/18/16
Occurrence Code: A3 Occurrence Date: 07/17/16
50 Occurrence Date: 06/01/16
Value Code: 80 Associated Amount: $16.00
81 Associated Amount: $15.00
82 Associated Amount: $9.00
23 Associated Amount: $500.00

Condition Codes:
Attending Provider Name: John Smith Attending Provider NPI: 13160999999

Claim Continued on Next Slide
Claim TPL Information

Other Insured Information

Other Insured Name: Test Thirtyfive  ID: 015574619A  Claim Filing Code: MA – Medicare Part A

Other Payer Information:

Other Payer Name: Medicare  Other Payer Identifier: 365252525252

TPL Code: 909  TPL Status Code: 01- TPL Adju  Payer Paid Amount/ TPL Amount: $3300.00

Deductible: $0.00  Coinsurance: $1500.00  CoPayment: $0.00

Adjudication or Payment Date: 08/01/2016

Service Line Information

Service Line 1

Revenue Code: 0110

Unit Code: DA-Days  Unit Count: 29  Line Item Charge Amount: $30100.00

Denied or Non-Covered Charge Amount:

Service From Date: 07/01/2016

Service Line 2

Revenue Code: 0185

Unit Code: DA-Days  Unit Count: 2  Line Item Charge Amount: $3000.00

Denied or Non-Covered Charge Amount:

Service From Date: 07/18/2016

Service Line 3

Revenue Code: 0022

Procedure Code: BA160

Unit Code: DA-Days  Unit Count: 1  Line Item Charge Amount: $0.00

Denied or Non-Covered Charge Amount:

Service From Date: 07/18/2016

Medicare Covered Day Determination:

• Statement From Date (07/01/16) through (Occur Code A3 07/17/16) = 17 Medicare Covered Days
• 17 Medicare Covered Days – 9 Coinsurance Days (Value Code 82) = 8 Full Medicare Covered Days
• Statement From Date 07/01/16 + 8 Full Medicare Covered Days = Full Medicare End Date 07/08/16
• Coinsurance Begin Date 07/09/16 = 9 Coinsurance Days (Value Code 82) = 07/17/16 Coinsurance End Date

HFS Paper Remit Coding

• 07/01/16 – 07/05/16  5 days COS 65
• 07/06/16 – 07/06/16  1 day  COS 70 BR Type 11
• 07/07/16 – 07/08/16  2 days COS 65
• 07/09/16 / 07/17/16  9 days COS 72
• 07/18/16 – 07/18/16  1 day  COS 70 BR Type 11
• 07/19/16 – 07/31/16  13 days COS 70
The Claim has been submitted. Date: 05/18/16 Time: 12:03 Confirmation Number: 000041714
Submitter Tax Id: 123456789003 Submitter Name: ACME LTC TEST
Submitter Contact Name: JANE DOE
Submitter Contact E-mail Address: JANED@GMAIL.COM
Total Net Amount Billed: 1500.00 Total TPL Payments: 0.00

Patient/Ssubmitter Information
Recipient ID Number (RIN): 015574619 Recipient Name: TEST THIRTYFIVE Date of Birth: 11/08/1921
Gender: Female
Recipient Address:
Address Line 1: 201 S GRAND Address Line 2: City: SPRINGFIELD State: IL Zip Code: 62763

(Billing) Provider Information
Provider: 123456789003 NPI: 1234567893 Provider Taxonomy Code: 315P00000X

Claim Information
Patient Account Number: 121212121212 Type of Bill Frequency Code: 3 - Interim Continuing Claim
Delay Reason Code: 
Total Claim Charge Amount: $3100.00 Type of Bill Facility Code: 79 - Developmental Training
(Type) of Admission or Visit: 3 - Elective Point of Origin for Admission or Visit: 9 - Info Not Avail
Patient Discharge Status: 30 Prior Authorization Number: Original DCN: Medical Record Number:
Admission/Start of Care Date: 07/01/2016 Admission Hour: Discharge Hour: 
Statement From Date: 07/01/2016 Statement Through Date: 07/31/2016

EPSDT Screening
Was this patient referred for services as a result of an EPSDT screening? No

Attachment Information
Type of Attachment: Attachment Control Number:

Principal Diagnosis and Procedure Codes
Principal Diagnosis: Z789 POA Indicator: Admitting Diagnosis: E Diagnosis: POA Indicator: Y

Value, Condition, and Occurrence Code Information
Accident State:
Occurrence Span Code: From Date: To Date: 
Occurrence Code: Occurrence Date: 
Value Code: 80 Associated Amount: $31.00
Value Code: 24 Associated Amount: $555.00
Condition Codes:

Physician Information Attending Physician Information
Attending Provider Name: John Smith Attending Provider NPI: 13160999999

Claim TPL Information
Claim TPL Line 1

Other Insured Information
Other Insured Name: Test Thirtyfive ID: DD222222 Claim Filing Code: CI- Commercial Insurance

Other Payer Information
Other Payer Name: Other Payer Identifier:
TPL Code: TPL Status Code: Payer Paid Amount/ TPL Amount: 
Deductible: Coinsurance: CoPayment:
Adjudication or Payment Date:

Claim Continued on Next Slide
Intermediate Care Facility for the Intellectually Disabled (IID) – Provider Type 029
Intermediate Care (COS 073) Developmental Training  EXAMPLE: 6 cont.

**Service Line Information**
Service Line 1
Revenue Code: 0942
Unit Code: DA-Days  Unit Count: 20  Line Item Charge Amount: $1500.00
Denied or Non-Covered Charge Amount:
Service From Date: 07/01/2016

Number of days attended: 32