*i*Care Guide for Skilled Nursing Facilities CLAIMS PROCESSING OVERVIEW

Disclaimer: This information is provided as a courtesy from *i*Care to assist you in claims submission billing. This is not in the place of the Forward Health and CMS Guidelines. *i*Care relies upon Forward Health and CMS for payment rules and submission requirements.

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*i*Care Skilled Nursing (SNF) UB-04 GUIDELINES

Box	Description	Comments
1	Provider Name and Address	
4	Bill Type	
5	Federal Tax ID	
6	Statement Covers Period	Not required for Bill type 322 or 323
8b	Patient Name	
9a-e	Patient Address	
10	Date of Birth	
11	Patient Sex	
12	Admission Date	Required for Inpatient, Home Health, and SNF claims
14	Admission Type	*Inpatient claims only*
15	Admission Source	
17	Discharge Status	Not required for Rural Health or Federally Qualified Clinics
35		Not required
42	Revenue Codes	⇨ **MEDICAID:** 019X and 018X for leave of absence. *PLEASE NOTE: *Claims should **NOT** be billed with revenue codes 0110-0129. These are non-covered.* ⇨ **MEDICARE:** • First line - Box 42- Rev 0022 (Same line Box 44 five (5) digit Medicare RUGS code) • Second line – 012X Room & Board ⇨ **DUAL ELIGIBLE:** • First line – Box 42- Rev 0022 (Same line Box 44 five (5) digit Medicare RUGS code) • Second line - 019X Room-Board • *PLEASE NOTE: Claims submitted without this information will be denied. *(See Example)*
44	RUGS Codes	⇨ **MEDICAID:** The required three (3) digit code ⇨ **MEDICARE:** The required five (5) digit code ⇨ **DUAL ELIGIBLE:** In order to avoid the companion claim (Medicaid claim) from denying, the Medicaid RUGS-48 code needs to be included on the R & B line. *(See Example)*
45	Service Date	Required for Home Health
46	Service Units	Total units should equal the total confinement days
47	Total/Line Item Charges	⇨ **Negative Amount:** Claim will reject for "No Dollar Amount". ⇨ Total Charges MUST equal the sum of the line item charges or claim will reject "Total charge does not match line charge totals". ⇨ Total charges on claim with Revenue Codes 0022 must be zero.
49	Unlabeled	
56	NPI	
57a-c	Other Provider ID	Required for ESRD claims
58a	Insured's Name	
59a	Relationship to Uninsured	
60a	Insured Identification No#	
67	Primary Diagnosis Code	Box 67a-67Q other diagnosis code Present on Admission Indicator
69	Admitting Diagnosis Code	Inpatient claims only
80	Remarks	Disclaimer M7-M8
81a-d	Taxonomy Code	⇨ **ELECTRONIC SUBMISSIONS:** Loop N0# 2000A_BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL, Segment PRV,element PRV02-PXC, PRV03=value populated ⇨ **PAPER SUBMISSIONS:** B3Taxonomy

EXAMPLES:

1) Medicaid – Room and Board

1	3a PAT. CNTL #	4 TYPE OF BILL
MEDICAID CLAIM EXAMPLE	123456	
Lake Michigan Rehab	b. MED. REC. # 123456	213
2115 E. Michigan Pl	5 FED. TAX NO. 21221212	6 STATEMENT COVERS PERIOD FROM 110114 THROUGH 113014
Milwaukee, WI 53202		

Print Form | RESET

8 PATIENT NAME	9 PATIENT ADDRESS
Patient, IMA	2115 E Michigan Place, MILWAUKEE, WI 53202

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
01011929	M	110112	15	3	4		30

38	39 VALUE CODES CODE	AMOUNT
ICARE P.O. BOX 660346 DALLAS, TX 75266-0346	a 80	3000

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
194	ACCOMMODATES	RAA		30	4584.00	

2) Medicare – Room and Board

1	3a PAT. CNTL #	4 TYPE OF BILL
Medicare	123456	
Lake Michigan Rehab	b. MED. REC. # 123456	212
2115 E Michigan Pl	5 FED. TAX NO. 2121212	6 STATEMENT COVERS PERIOD FROM 110114 THROUGH 113014
Milwaukee, WI 53202		

PrintForm | RESET

8 PATIENT NAME	9 PATIENT ADDRESS
Patient, IMA	2115 E Michigan Pl, Milwaukee, WI 53202

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
1011929	M	110114	15	3	4		30

38	39 VALUE CODES CODE	AMOUNT
ICare P.O. Box 660346 Dallas, Texas 75266-0346	a 80	3000

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0022		RVC40		9		
120	Room and Board			30	5000 00	

3) Dual Eligible – Example

Medicare Prime and Dual Member claims for R&B and Therapies need to be billed on one claim.

X Provider Name
X Address
X City, WI 53202

Print Form
RESET

123456
123456
213

123456789 | 110114 | 113014

2115 E Michigan Pl

Doe, John | Milwaukee | WI | 53202

01011945 | M | 082414 | 14 | 3 | 4 | 30

50 | 101914 | 50 | 111614 | 50 | 112114

iCare
P.O. Box 660346
Dallas, Texas 75266-0346

80 | 3000

Rev. Code	Description	HCPCS / Rate / HIPPS Code	Serv. Date	Serv. Units	Total Charges
0022					
0022		RVC40	110114	9	
0022		RUC00	111614	12	XXXXX
0194	Room & Board/PVT	435.91 RAC		9	
0194	Room & Board/PVT	566.40 RAD		21	
0250	Pharmacy		113014	1	
0420	physical therapy		113014	64	
0430	Occupational therapy		113014	70	
0440	Speech therapy		113014	23	
0001	PAGE 1 OF 1	CREATION DATE	XXXX	TOTALS	XXXXXXXPa

Payer Name			NPI / Other Prv ID
Medicare	Y	Y	XXXXXXXXXX
iCare	Y	Y	XXXXXXXXXX
			XXXXXXXXXX

Insured's Name	P. Rel	Insured's Unique ID
Patient, Doe	18	C111100000
Patient Doe	18	4500000000

V5789 | 29000 | 436 | 3310

Admit Dx: V5789

Attending NPI: XXXXXXXXXX
Last: X | First: X

Remarks: XX Disclaimer code M7 or M8

XX | X Taxonomy

5) Medicaid Therapies:

*i*Care has determined that Medicaid covered therapy services provided in a skilled nursing facility must be billed in the following manner to be considered for payment.

- Claims must be submitted on a CMS 1500 form.
- The rendering provider on the CMS 1500 form must be a provider qualified to provide therapy service.
- Providers may submit claims for these services under the nursing home NPI, but should refer to the appropriate service areas for more information about covered services, service limitations under the BadgerCare Plus Benchmark Plan, prior authorization guidelines, and claim submission instructions. (ForwardHealth Topic 3215)
- When the rendering provider is employed by, or under contract to, a therapy group, therapy clinic, speech and hearing clinic, or nursing home, the billing provider number of the group, clinic, or nursing home must be indicated on the claim. A performing provider number must be indicated. (ForwardHealth Topic 2765)
- When the rendering provider is employed by or under contract to a rehabilitation agency, the billing provider number of the rehabilitation agency must be indicated on the claim. A rendering provider number should not be indicated (ForwardHealth Topic 2762)
- Claims can contain the services from only one rendering provider per claim form.
- Claims for PT, OT, and SLP services require the referring physician's name and NPI.

An example of claims with an explanation of the required fields is attached for your reference. More information is available at Forward Health (www.forwardhealth.wi.gov).

In order for us to process these claims efficiently, please send us a roster of the therapists that will bill under your NPI. Please include the therapist name, credential and NPI number.

iCare Requirements for Clean Claim (CMS 1500)

Box	Description	Comments
1a	Insured's ID Number	
2	Patient Name	
3	Birth Date and Sex	Date of birth must be valid date and not future date
5	Patient Address	
12	Patient's or Authorized Person's Signature and Date Signed	Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with "X", Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging
21	Diagnosis or Nature of Illness	
24a	Dates of Service	Claim must include one detail line, must be a valid date, From date cannot include a future date, cannot have a date span into the future, cannot span a calendar year
24b	Place of Service	Must be 2 characters
24d	Procedures, Services or Supplies	Must be at least 5 characters
24f	Charges	A negative amount will be neglected
24g	Days or Units	
24i/j	Taxonomy code and prefix	Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted.
24J (b)	NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99
25	Federal Tax ID Number	Must be 9 numerical characters
28	Total Charge	Total charges must equal the sum of the line charges
31	Signature of Physician or Supplier Physician	Not required for SMV claims billed with POS 41,42,99
33	Physician/Provider's Name, Billing Address, Zip Code	
33a	Billing Physician/Provider NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42,99. The Medicaid provider must be certified as a billing provider.
33b	Taxonomy code and prefix	Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number 2310A-BILLING PROVIDER NAME, Segment PRV, ElementPRV02 =PXC, ElementPRZ03=value populated taxonomy code

Updated 5/8/2015- Paper Claims must signed and dated

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | | PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE (MM DD YY) / SEX: 11 21 1932 M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANTYOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (444)4444444

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH (MM DD YY) / SEX: M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. V57 89 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11 18 2014	11 18 2014	31		97001	GP	I	125 00	2		NPI	0111111111
2	11 18 2014	11 18 2014	31		97116	GP	I	80 00	2		NPI	0111111111
3	11 19 2014	11 19 2014	31		97110	GP	I	40 00	1		NPI	0111111111
4	11 19 2014	11 19 2014	31		97116	GP	I	80 00	2		NPI	0111111111
5	11 20 2014	11 20 2014	31		97110	GP	I	40 00	1		NPI	0111111111
6	11 20 2014	11 20 2014	31		97116	GP	I	80 00	2		NPI	0111111111

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789 [ ][ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE: $ 480 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JOHN R JOHN SR 12 03 2014

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. | b.

33. BILLING PROVIDER INFO & PH # ( )

IM A BILLING ONLY LCINIC
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 | b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER | PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION