*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.

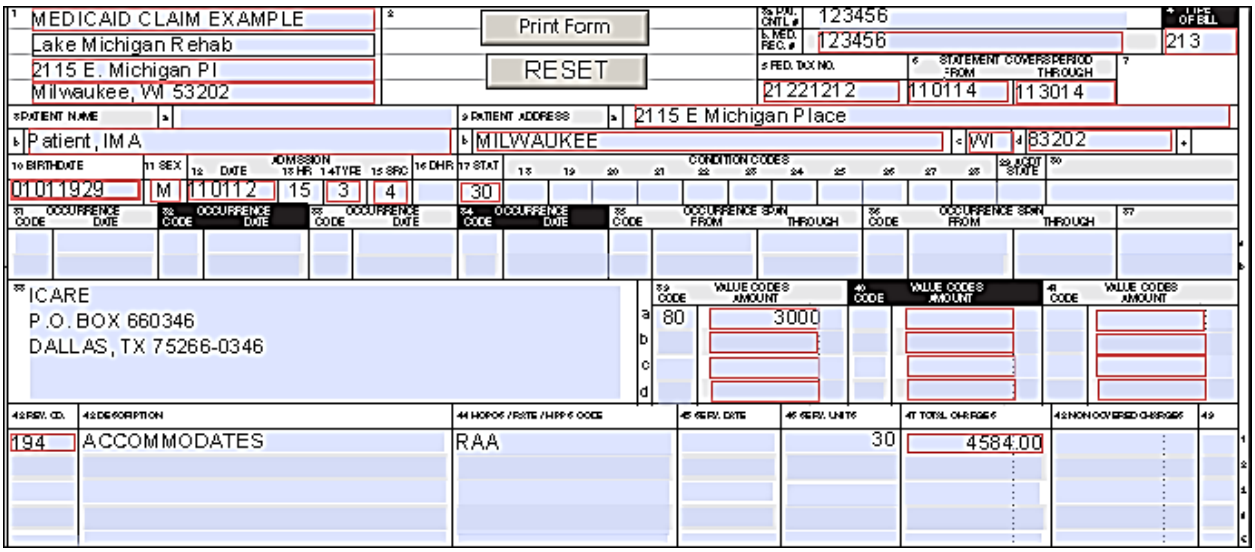
SECTION **PAGE**

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

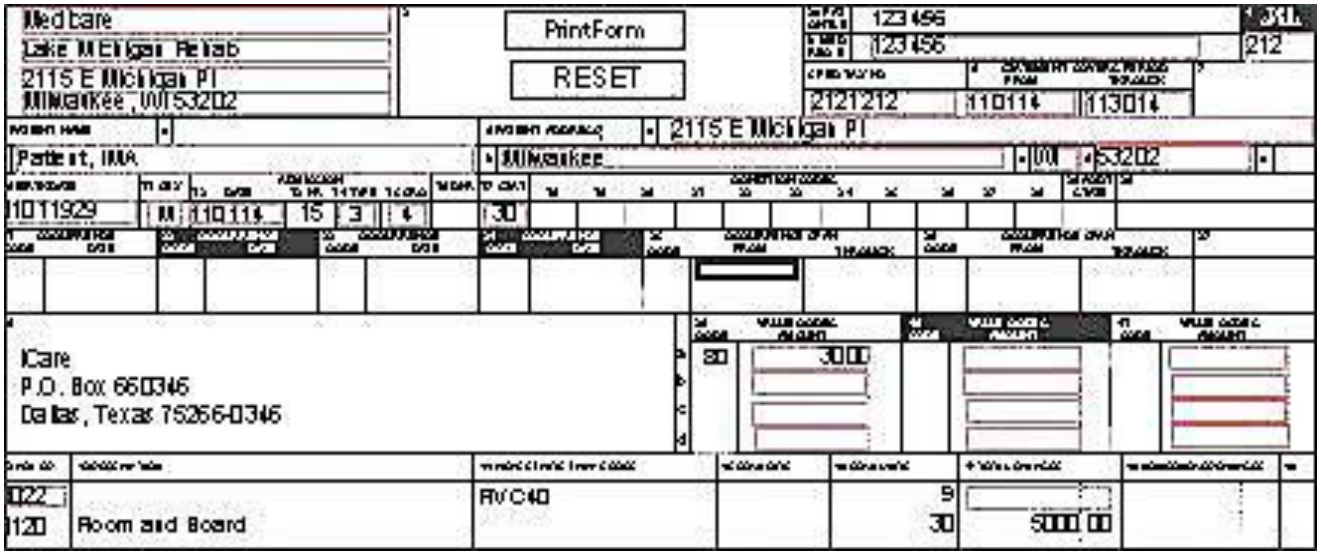
Box	Description	Comments
1	Provider Name and Address	
4	Bill Type	
5	Federal Tax ID	
6	Statement Covers Period	Not required for Bill type 322 or 323
8b	Patient Name	
9a-e	Patient Address	
10	Date of Birth	
11	Patient Sex	
12	Admission Date	Required for Inpatient, Home Health, and SNF claims
14	Admission 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

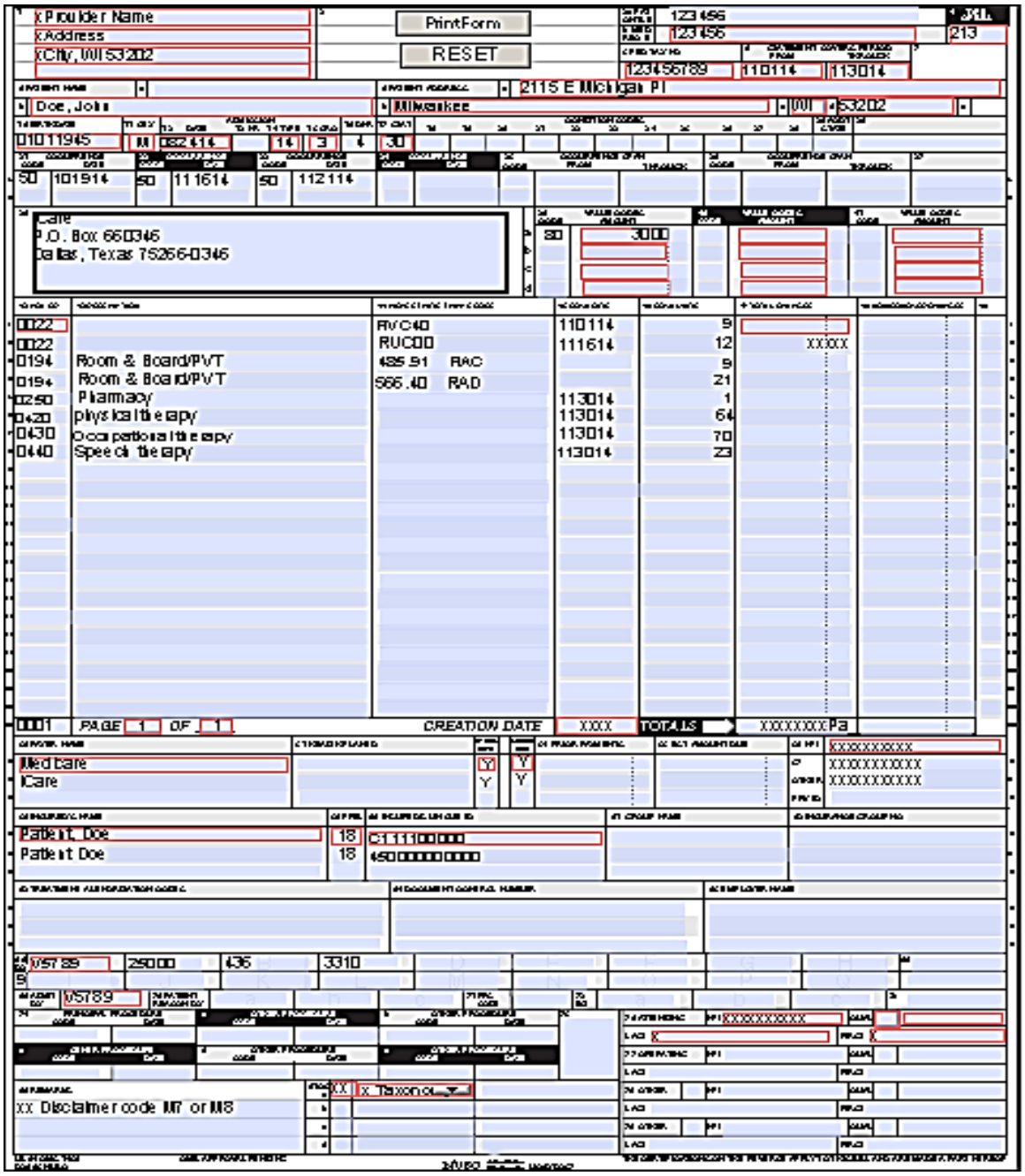


2) Medicare – Room and Board



3) Dual Eligible – Example

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



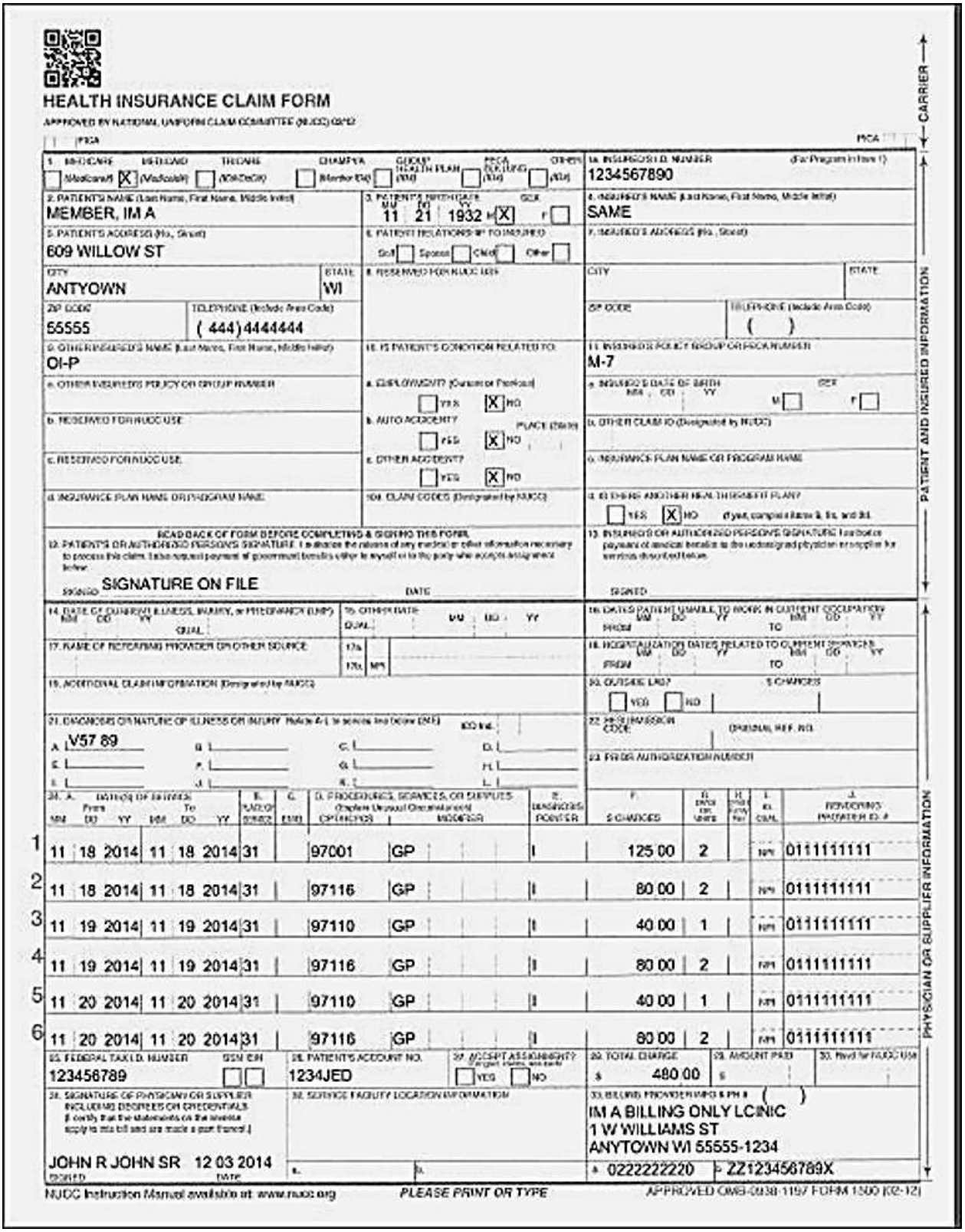
5) Medicaid Therapies:

*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.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (08/05) 0D12

PICA

CARRIER

1. MEDICARE [X] (Medicare#) MEDICAID (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: 11 21 1932 SEX: 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 [ ] NO [X]
a. INSURED'S DATE OF BIRTH: SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
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 [ ] NO [X] 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:

PATIENT AND INSURED INFORMATION

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: MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO MM DD YY
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 (Explain Unusual Circumstances) 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	1	125 00	2		NPI	0111111111
2 11 18 2014	11 18 2014	31		97116	GP	1	80 00	2		NPI	0111111111
3 11 19 2014	11 19 2014	31		97110	GP	1	40 00	1		NPI	0111111111
4 11 19 2014	11 19 2014	31		97116	GP	1	80 00	2		NPI	0111111111
5 11 20 2014	11 20 2014	31		97110	GP	1	40 00	1		NPI	0111111111
6 11 20 2014	11 20 2014	31		97116	GP	1	80 00	2		NPI	0111111111

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN EIN [ ]	26. PATIENT'S ACCOUNT NO.: 1234JED	27. ACCEPT ASSIGNMENT? 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 CLINIC 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X		

PHYSICIAN OR SUPPLIER INFORMATION

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

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
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