Humana Quick Reference Guide for Assistive Care Services

Below are instructions to help assisted living facilities and adult family care homes submit claims to Humana using the **CMS-1500** claim form. Refer to a sample of the CMS-1500 claim form on Page 3 as you review these instructions. Please fill out all applicable boxes on the CMS-1500 claim form; those boxes without instructions should be self-explanatory.

Instructions for Using the CMS-1500 Claim Form

- Box 1A: Enter the client's Humana member ID (not the Medicaid ID).
- Boxes 2 – 8: Enter the client's name and demographic information.
- Box 10: Check either "yes" or "no" for each question.
- Boxes 12 – 13: Must be completed. Normally, this is populated with either a signature or the statement "Signature on File" along with the appropriate date provided in box 12.
- Box 21: Enter the diagnosis code. If you do not know the diagnosis code, you can use code 799.3 (debility unspecified).
- Box 24: Must be completed.
  - Confirm that the date span in box 24A agrees with the number of units in box 24G.
  - Enter place of service code "13" in box 24B.
  - Enter code "T1020" in box 24D for assistive care services.
  - Use box 24E to align the diagnosis with the procedure/service billed. This will normally be "1" for claims with only one diagnosis provided in box 21. If multiple diagnoses are listed in box 21, box 24E should be used to point to the applicable code for the service.
  - Include the billed charge amount in box 24F.
  - Use box 24G to enter the number of units in which this service was provided during the date span identified in box 24A.
  - Enter your NPI in box 24J.
- Box 25: Enter your federal tax ID number.
- Box 26: Enter the client's account number (i.e., the provider's internal account number for the client).
- Box 27: Select "Y" to accept assignment.
- Box 28: Enter total charges.
- Box 29: Enter total amount paid, including all monies received from other insurance sources.
- Box 30: Enter the balance due.
- Box 31: Sign the form per the instructions in the box.
- Boxes 32 – 33: Enter the service and billing information.
  - Enter your NPI in boxes 32a and 33a.

Paper Claims

Humana Claims
P.O. Box 14601
Lexington, KY 40512-4601

Electronic Claims

Availity® is Humana's central gateway for electronic data interchange (EDI) transactions. Humana-contracted health care providers can also use Availity as a no-cost solution for sending claims electronically. Visit Availity.com or call Availity's Customer Service at 1-800-282-4548 for more information about direct claim submission.

Also, visit https://www.humana.com/provider/medical-providers/education/claims/electronic-submission for more information on electronic claims submissions.

Timely Filing

Health care providers must submit claims to Humana within 180 days of the date of service for assistive care services.

Humana Provider Self-Service Resources

You may save time, increase efficiency and help improve your practice's bottom line by using Humana's self-service resources. These secure Web tools allow you to check patient eligibility and benefits, manage claims, submit referrals and authorizations and complete other tasks. View our schedule of provider webinars at https://www.humana.com/provider/medical-providers/education/provider-self-service/interactive to learn more or register for access today at Humana.com/provider. Choose "Sign in or Register," and then "Register now" to get started.

Additional Resources:

Please see the additional statewide Medicaid Managed Care document from the Agency for Health Care Administration (AHCA) regarding assistive care services on Pages 4 and 5.

If you have additional questions, please contact Paula Sierra at 1-305-626-5228 or psierra@humana.com.

Thank you for your participation with the Humana Medical Plan.

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Sample CMS-1500 Claim Form

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self Spouse Child Other

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

CITY | STATE

8. PATIENT STATUS — Single Married Other

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes**, return to and complete item 9 a-d.*

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 ______ 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: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID 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. #
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION — a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) — a. b.

PHYSICIAN OR SUPPLIER INFORMATION

FLHHZVEEN 1829FL0617-E

Humana

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

STATEWIDE MEDICAID MANAGED CARE PROGRAM SERVICE: ASSISTIVE CARE SERVICES

Assistive care services (ACS) are an integrated set of 24-hour services only for eligible Medicaid enrollees. The assistive care service is a required service in the statewide Medicaid Managed Care program under both the long-term-care program and the Managed Medical Assistance program.

	Statewide Medicaid Managed Care (SMMC) Program	
	Long-term-care (LTC) Program	**Managed Medical Assistance (MMA) Program**
What are assistive care services?	An integrated set of 24-hour services only for eligible Medicaid recipients. ACS require a health assessment by a licensed practitioner establishing the need for at least one specific service each day and the need for at least two of the following four service components: • Health support, • Assistance with activities of daily living, • Assistance with instrumental activities of daily living, or • Assistance with self-administration of medication.	An integrated set of 24-hour services only for eligible Medicaid recipients. ACS require a health assessment by a licensed practitioner establishing the need for at least one specific service each day and the need for at least two of the following four service components: • Health support, • Assistance with activities of daily living, • Assistance with instrumental activities of daily living, or • Assistance with self-administration of medication.
Who can receive assistive care services?	Enrollees who are 18 years of age or older and meet following requirements: • Are Medicaid-eligible and enrolled in the LTC program. • Have a health assessment completed by a licensed practitioner acting within his/her scope of practice indicating the need for two of the four service components; and • Reside in an adult family-care home.	Enrollees who are 18 years of age or older and meet following requirements: • Are Medicaid-eligible and enrolled in the MMA program; • Have a health assessment completed by a licensed practitioner acting within his/her scope of practice indicating the need for two of the four service components; and • Reside in an assisted living facility, residential treatment facility or adult family care home.
Who can provide assistive care services?	The following facility type is eligible to be reimbursed for ACS: • Adult family care home (AFCH)* ***NOTE**: In the LTC program, ACS is included in the assisted living facility service rate and is not separately reimbursed.	The following facility types are eligible to be reimbursed for ACS: • Assisted living facility (ALF) • Residential treatment facility (RTF) • Adult family care home (AFCH)

Please see the Medicaid *Assistive Care Services Coverage and Limitations Handbook* posted on the fiscal agent's website for more information on service requirements.

Medicaid reimburses for ACS using the following procedure codes:

Code	Unit(s)	Per Diem Rate*
T1020	Daily	$12.25

*2014 HB 5001 (General Appropriations Act) incorporated rate increases for several types of Medicaid providers effective July 1, including assistive care services. As a result of this change, the Agency will amend fee schedules for payments under the fee-for-service system to reflect the increase of $12.25.

Managed care plans and network providers negotiate individual rate agreements through contract. Negotiated rates can be based on or tied to the fee-for-service fee schedules or otherwise calculated. Plans are not required to use the fee schedules as the basis of their payment to network providers.

No explicit adjustments were made to MMA capitation rates to account for these fee increases. The base capitation rates negotiated with managed care plans as part of the MMA procurement process included assumptions regarding expected trends in nonhospital payment levels, and these fee increases are not out of line with those assumptions.

Providers should continue providing services that were previously authorized, regardless of whether the provider is participating in the plan's network. Plans must pay for previously authorized services for up to 60 days after MMA starts in each region.

For the first 30 days of the continuity of care period, managed care plans must reimburse nonparticipating providers at the rate previously received by the provider. For nonparticipating providers previously reimbursed under the fee-for-service system, the rate during this 30-day portion of the continuity of care period is the posted rate in the fee schedule as of the first date of the rollout in their region.

Providers receiving reimbursement through a Medicaid managed care plan should refer to their contract with each plan to determine whether this change will impact their reimbursement from the plan.

Additional requirements under the MMA program:

- In order for the provider to receive reimbursement for assistive care services under the MMA program, the provider must have an agreement or contract with the enrollee's MMA plan.
- If an enrollee chooses to enroll in an MMA plan that does not have an agreement/contract with his/her provider and he/she is receiving assistive care services, the plan is not obligated to continue to pay for assistive care services after the initial 60-day continuity of care period.
- After the 60-day continuity of care period, if the provider is not under contract with the MMA plan, the plan may authorize home health services in order to meet the enrollee's need for assistance with activities of daily living. Florida Medicaid covers home health services that are provided in an ALF or AFCH as long as it does not duplicate another service that the enrollee is receiving. For more information on home health service requirements, please review the Medicaid *Home Health Services Coverage and Limitations Handbook*.
- The enrollee cannot be forced to move to another facility that is under contract with his/her MMA plan or to transition to a plan that is under contract with his/her provider.