# Humana Gold Plus Integrated Plan

## A Commonwealth Coordinated Care Plan

Long-term Services and Supports (LTSS) Provider Billing Guide

Effective: Jan. 1, 2017

Revised: July 1, 2017

1583VA0916-C VAHJTRHEN

# PROVIDER BILLING GUIDE – VIRGINIA
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# HUMANA-APPROVED CLAIM FORMS FOR BILLING

To assist health care providers in understanding how to properly populate approved billing forms, we have composed this billing guide. This document contains detailed instructions for completing the mandatory areas of the various claim form types Humana uses.

A claim is defined as a request for payment for benefits or services rendered to a beneficiary. When you provide covered services to a Humana member, you are required to submit a claim to Humana for payment processing.

Humana allows participating network health care providers to submit claims in either paper or electronic format. Those submitting paper claims must use one of the following approved standard forms.

| Form types | Form descriptions | Example |
|---|---|---|
| CMS-1500 Claim Form | The official standard form used by physicians, private insurers, managed care plans and other provider types when submitting bills/claims for reimbursement to Medicare or Medicaid for health services. CMS-1500 contains patient demographics, diagnostic codes, CPT/HCPCS codes, diagnosis codes and units. | |
| UB-04/CMS-1450 Claim Form | The UB-04 claim form is the nationally recognized bill form used by hospitals, payers, health care service facilities and other institutional providers, such as nursing homes. | |

# SUBMITTING CLAIMS TO HUMANA FOR PAYMENT

## PAPER CLAIM SUBMISSION INSTRUCTIONS

Humana encourages health care providers to submit claims electronically; however, if you need to submit via paper, we will accept claims submitted on the red and white claim forms. Although the manual entry process increases the claims processing time, Humana remains committed to paying all health care providers in a timely and accurate manner. All completed paper claims should be mailed to the following address for processing:

Humana
P.O. Box 14732
Lexington, KY 40512-4732

## ELECTRONIC CLAIMS AND ELECTRONIC DATA INTERCHANGE (EDI) TRANSACTIONS

## FREQUENTLY ASKED QUESTIONS

**Q: Can I submit Humana Gold Plus Integrated claims to Humana electronically?**

**A:** Yes. Providers can submit claims through Direct Data Entry on the Availity portal at **www.availity.com**. Availity offers a free web tool for health care providers to upload batch claims electronically. The following requirements should be met:

- Health care providers must register for a user account on **www.availity.com**.
- Health care providers should have claims software with EDI file-creation capabilities.

**Q: How do I get started with electronic claims?**

**A:** Health care providers who already have an EDI solution or electronic billing software will need to set up Humana as a payer in their systems before they are able to submit claims electronically. Humana uses Availity as its EDI vendor. On all systems, except ZirMed, the Humana EDI payer ID is 61115. Please use this number for arranging for transfer of information from your clearinghouse to Availity.

**Q: What if I don't contract directly with your clearinghouse?**

**A:** Though Humana uses Availity as its clearinghouse for EDI claims, we do not recommend any specific EDI solution. You are free to select whatever vendor you wish to use. If your system vendor submits claims through another clearinghouse, that intermediary clearinghouse will forward your Humana claims to Availity.

**Q: Which payer ID should I use if I transmit claims using ZirMed?**

A: The Humana EDI payer ID for ZirMed is 61101. Please use this number when arranging for transfer of information from your clearinghouse to Availity.

**Q: How do we set up the payer ID within the software system used in my office?**

**A:** Humana uses Availity as its EDI vendor. On all systems except ZirMed, the Humana EDI payer ID is 61115 and must be set up in your practice management system or billing system as an available EDI claim payer ID. EDI connectivity is related to your billing system or practice system vendor. Since all software systems work differently, your practice management or billing system vendor can provide you with instructions on how to add an additional payer ID into the system.

**Q: Whom do we contact if we have difficulty submitting claims electronically?**

**A:** Connectivity among EDI vendors, clearinghouses and payers is complex and comprehensive. Please contact your system vendor for answers to questions about claims connectivity for its clients.
Please be sure to use the proper payer information for Humana Gold Plus Integrated claims. Use of a payer ID or payer information other than the above may result in unpaid claims due to misrouting.
Technical support is provided by Availity Client Services at 1-800-282-4548.

## PROVIDER PROFILE UPDATE REQUEST

Please contact your provider relations representative to update your demographic information.

## CLAIMS INQUIRIES, RECONSIDERATIONS AND GRIEVANCES

Health care providers may inquire about claim status, payment amounts or denial reasons. To check on the status of outstanding claims, you may contact Humana at 1-855-280-4002.

A health care provider may also make a simple request for reconsideration by clearly explaining the reason the claim is not adjudicated correctly. Contact the claims department for information on how to request a claims adjustment or reconsideration. To file a claim-related grievance, please refer to the corresponding section of the provider manual that was provided to you or delivered to your office upon contracting.

Please also refer to your provider manual for information on timely claims submissions. To request a copy of the provider manual, call Humana at 1-855-280-4002. Upon receipt of your request, an electronic version can be emailed to you within 24 to 48 hours.

# QUICK CONTACT REFERENCE GUIDE

To assist you in day-to-day operations, we have included this Quick Contact Reference Guide to help you promptly reach the appropriate plan contacts.

**Humana LTSS Claims**
P.O. Box 14732
Lexington, KY 40512-4732

**Payer:** Humana
**Humana Payer IDs:**

- **Availity:** 61115 (long-term care), 61101 (fee for service), 61102 (encounter), 61105 (delegated encounters)
- **ZirMed:** 61101 (fee for service and long-term care), 61102 (encounter), 61105 (delegated encounters)

| Department | Function | Contact |
|---|---|---|
| **Provider Help Line** | Authorizations<br>Preauthorizations<br>Clinical coordination<br>Case management contact | Telephone: 1-855-280-4002<br>TTY: 711 |
| **Claims Department** | Billing assistance<br>Claims processing<br>Claims inquiry | |
| **Humana Customer Care Line** | Enrollee assistance<br>Benefit information | |
| **Provider Relations**<br>**Participating Providers** | Contracting<br>Credentialing<br>Education | |

**Submit paper claims to:**

P.O. Box 14732
Lexington, KY 40512-4732

**Contact for claims disputes:**

1-855-280-4002

**Commonwealth Coordinated Care** www.virginiaccc.com

**Humana Gold Plus Integrated** **Humana.com/vaduals**

# COMPLETING THE CMS-1500

CMS-1500 forms can be purchased via a variety of approved suppliers, such as Office Depot. Fillable PDF versions can also be purchased through online vendors. Fillable PDF templates can be completed on a computer. The completed form must also be printed, signed and mailed.

Some of the health care provider types that bill on the CMS-1500 include:

- Adult day care
- Homemaker agency
- Home health agency
- Pest control
- Personal care agency
- Personal emergency response system
- Service facilitators
- Environmental modifications

## BLANK CMS-1500 CLAIM FORM

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA | CARRIER

1. MEDICARE (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)

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. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES 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 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 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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY 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. 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 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI

PHYSICIAN OR SUPPLIER INFORMATION

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. 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

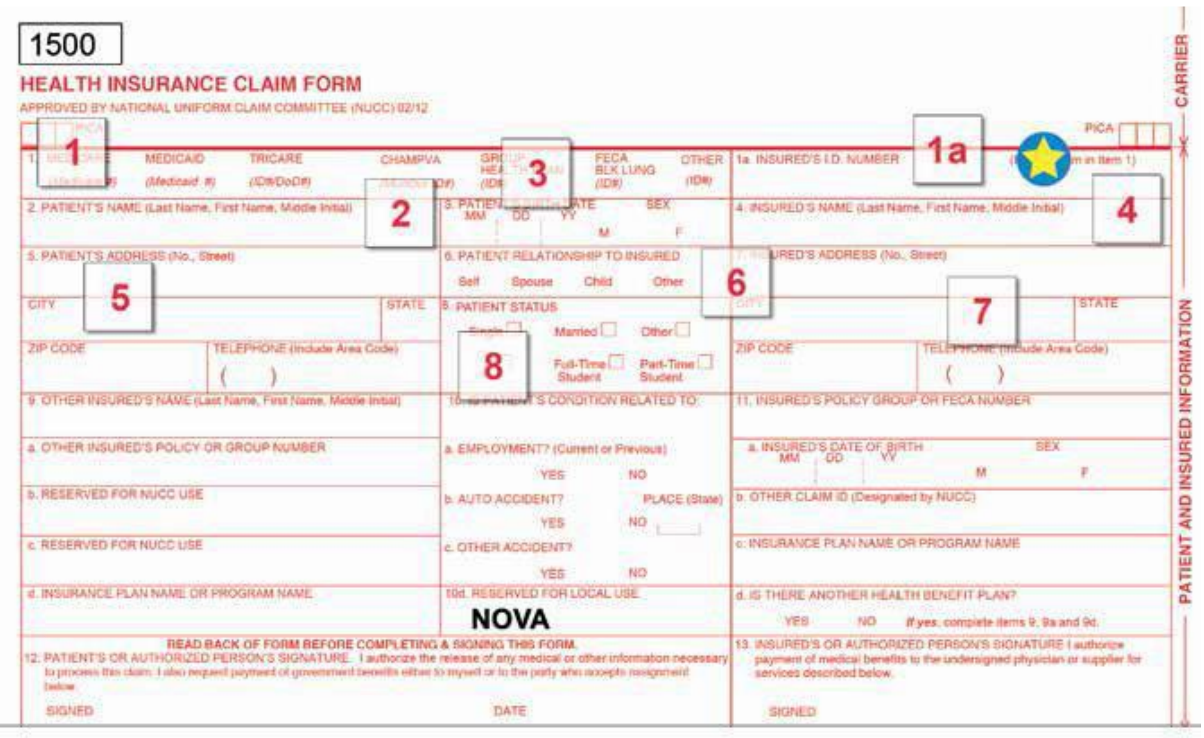
APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

## SECTION 1 – SUBSCRIBER INFORMATION

| # | Field name | # | Field name |
|---|---|---|---|
| 1a | **Insured's ID Number**<br>Enter the Subscriber ID as it appears on the insurance card. This number replaces the Medicaid ID number.* | 5 | **Patient Demographic Information**<br>Enter all of the patient's demographic information. |
| 2 | **Patient's Name (e.g., last name, first name)**<br>Enter the patient name in the format indicated. | 6 | **Patient Relationship to Insured**<br>Check the correct box to indicate the patient's relationship to the insured. |
| 3 | **Patient Date of Birth and Gender**<br>Enter birth date in mm/dd/yy format and check proper gender box. | 7 | **Insured Demographic Information**<br>Enter the demographic information of the insured. This is a required field. If patient and insured are the same, repeat the patient demographic information here. |
| 4 | **Insured's Name (e.g., last name, first name)**<br>Enter name of insured in the format indicated. | 8 | **Patient Status (Marital Status Only)** |

***Note: Insert the Humana-plan-issued member ID.**



1500

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (ID#/DoD#) (ID#) (ID#) (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 Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

NOVA

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 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.

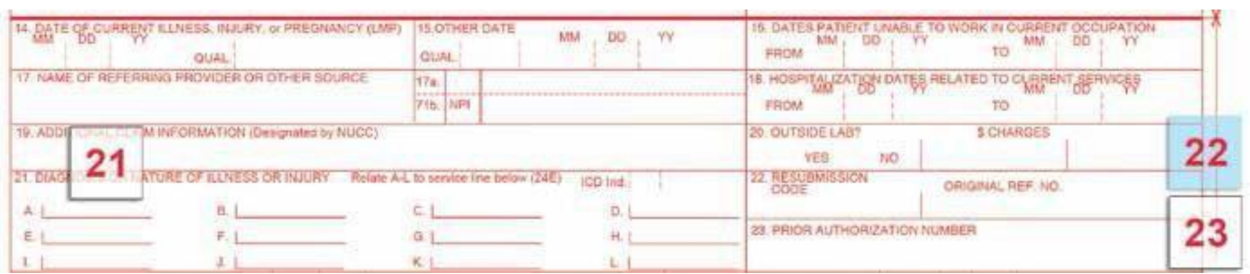
SIGNED

CARRIER

PATIENT AND INSURED INFORMATION

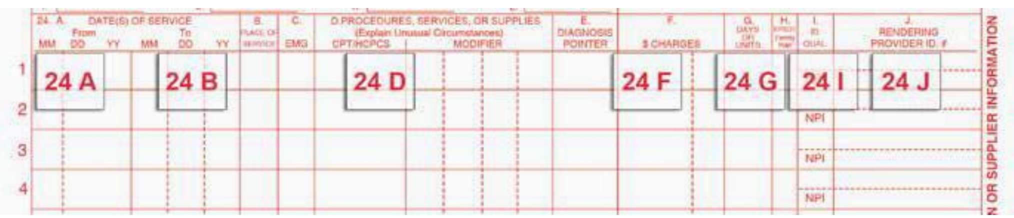
## SECTION 2 – DIAGNOSIS INFORMATION

| # | Field name | Field instructions |
|---|---|---|
| **21** | **Diagnosis or Nature of Illness or Injury** | Enter the diagnosis code included on the authorization or service request for the patient. If there is no code on the authorization form, use code R53.81 (Other malaise). In most cases, this will be the code used. |
| **22** | **Resubmission Code** | Enter code 7 (replace original claim) to indicate that this is a corrected or replacement claim. In the “Original Ref. No.” section, enter the number of the original claim you are replacing. This code is required only if resubmitting. |
| **23** | **Prior Authorization**<br>*All services must be authorized.*<br>**Please note that an authorization is not a guarantee of payment.* | Enter the authorization number listed on the service request form. If you have not received a new authorization number from the member’s new managed care plan, please contact the plan before billing to request that a new authorization be sent to you. |


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 MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY 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. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
21
22
23

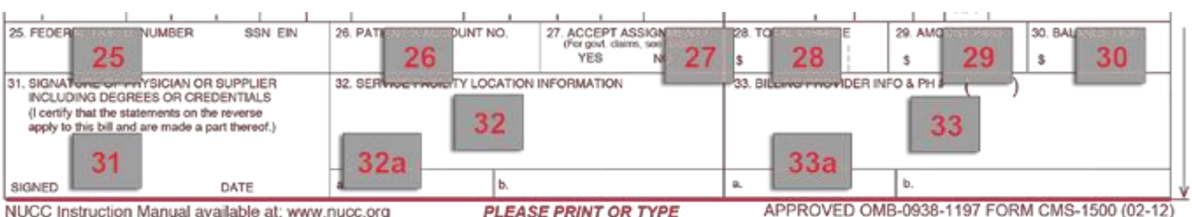
## SECTION 3 – SERVICE INFORMATION

| # | Field name | Field instructions |
|---|---|---|
| 24a | **Date(s) of Service** | Enter the date of service for each procedure, service or supply on an individual line. (Exception: Health care providers on a capitated agreement may use a date range for dates of service upon meeting their maximum allowable amount.) The form provides a maximum of six line entries. If claim surpasses the lines of entries provided, complete a separate CMS-1500 form for remaining entries. |
| 24b | **Place of Service** | Enter the two-character place of service code (as per the CMS-1500 Reference Guide). In most cases, code 12 will be used in this field. |
| 24c | **EMG** | Not applicable. |
| 24d | **Procedures, Services or Supplies** | Enter the CPT code(s) as listed on the authorization for service provided by Humana. In most cases, no modifiers will be needed. |
| 24e | **Diagnosis Pointer** | Not applicable. |
| 24f | **$ Charges** | Enter the charge amount for the service. Refer to Humana agreement for contracted rates. |
| 24g | **Days or Units** | Enter the days or units provided for the procedure. All authorizations should indicate the proper unit increment. |
| 24h | **EPSDT Family Plan** | Not applicable. |
| 24i | **ID Qualifier** | Enter the ID qualifier. *NPI only |
| 24j | **Rendering Provider NPI** | Enter NPI of the rendering provider. |

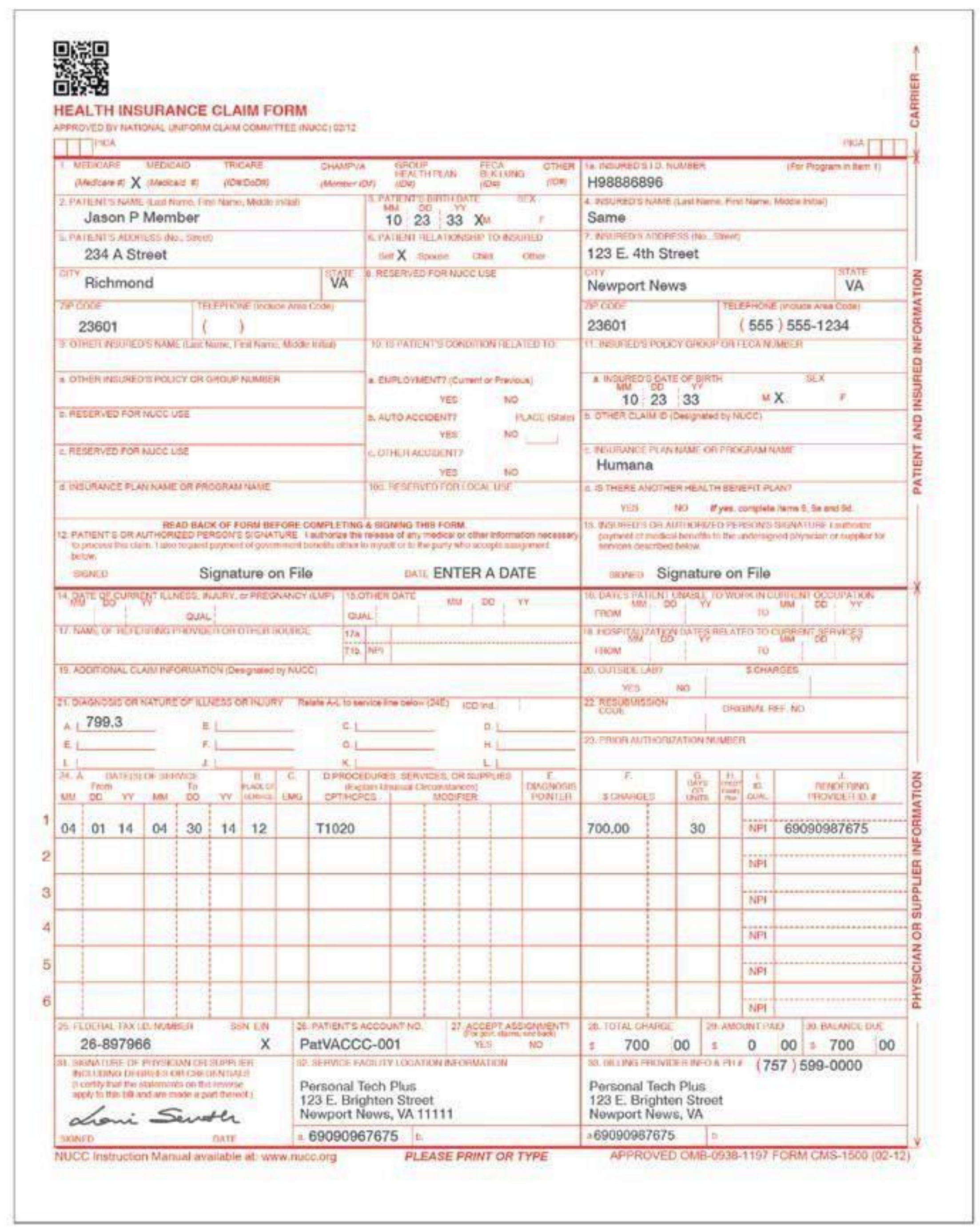


## SECTION 4 – BILLING AND FINANCIAL INFORMATION

| # | Field name | Field instructions |
|---|---|---|
| **25** | **Federal Tax ID Number** | Enter the health care provider's federal tax ID number (TIN or SSN) and check the box to indicate tax ID type. |
| **26** | **Patient Account No.** | Enter the patient's account number. This is the provider's internal account number for the patient. |
| **27** | **Accept Assignment** | Check "yes" to accept the assignment. |
| **28** | **Total Charge** | Enter the total charge for the services listed. |
| **29** | **Amount Paid** | Enter the total amount paid from all other insurance sources. |
| **30** | **Balance Due** | Enter the remaining balance due from Medicaid. |
| **31** | **Signature** | Signature of the person completing the form. |
| **32** | **Servicing Provider Location Information** | Enter the servicing health care provider's name, address and phone number. Include ZIP code + 4. |
| **32a** | **Servicing Provider NPI** | Enter the NPI of the servicing provider location. In some cases, this may differ from the billing provider location.<br><br>*32b: Not applicable.* |
| **33** | **Billing Provider Information and Phone Number** | Enter the billing provider's name, address and phone number. Include ZIP code + 4.<br><br>33a: Enter the NPI (same from 24i).<br><br>*33b: Not applicable.* |



## EXAMPLE OF A CLEAN CMS-1500 CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X — 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): H98886896

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jason P Member

3. PATIENT'S BIRTH DATE (MM DD YY): 10 23 33 — SEX: M X

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

5. PATIENT'S ADDRESS (No., Street): 234 A Street — CITY: Richmond — STATE: VA — ZIP CODE: 23601 — TELEPHONE (Include Area Code): ( )

6. PATIENT RELATIONSHIP TO INSURED: Self X — Spouse — Child — Other

7. INSURED'S ADDRESS (No., Street): 123 E. 4th Street — CITY: Newport News — STATE: VA — ZIP CODE: 23601 — TELEPHONE (Include Area Code): (555) 555-1234

8. RESERVED FOR NUCC USE

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO — b. AUTO ACCIDENT? YES NO PLACE (State) — c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH (MM DD YY): 10 23 33 — SEX: M X

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: Humana

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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: ENTER A 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: Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) — 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. 799.3 — 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 | 04 01 14 | 04 30 14 | 12 | | T1020 | | | 700.00 | 30 | | NPI | 69090987675 |
| 2 | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER: 26-897966 — SSN EIN: X

26. PATIENT'S ACCOUNT NO.: PatVACCC-001

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

28. TOTAL CHARGE: $ 700 00 — 29. AMOUNT PAID: $ 0 00 — 30. BALANCE DUE: $ 700 00

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: Personal Tech Plus, 123 E. Brighten Street, Newport News, VA 11111 — a. 69090967675 — b.

33. BILLING PROVIDER INFO & PH #: (757) 599-0000 — Personal Tech Plus, 123 E. Brighten Street, Newport News, VA — a. 69090987675 — b.

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

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

# COMPLETING THE UB-04/CMS-1450 FORM

## BEST PRACTICES IN BILLING PROTOCOL (NURSING HOMES)

This document is meant to guide nursing homes and billing entities through the process of completing the UB-04. Links are included throughout this document that provide further explanation and detail about the nursing home claims process. More important, the links will allow you to submit accurate and compliant claims to the payers.

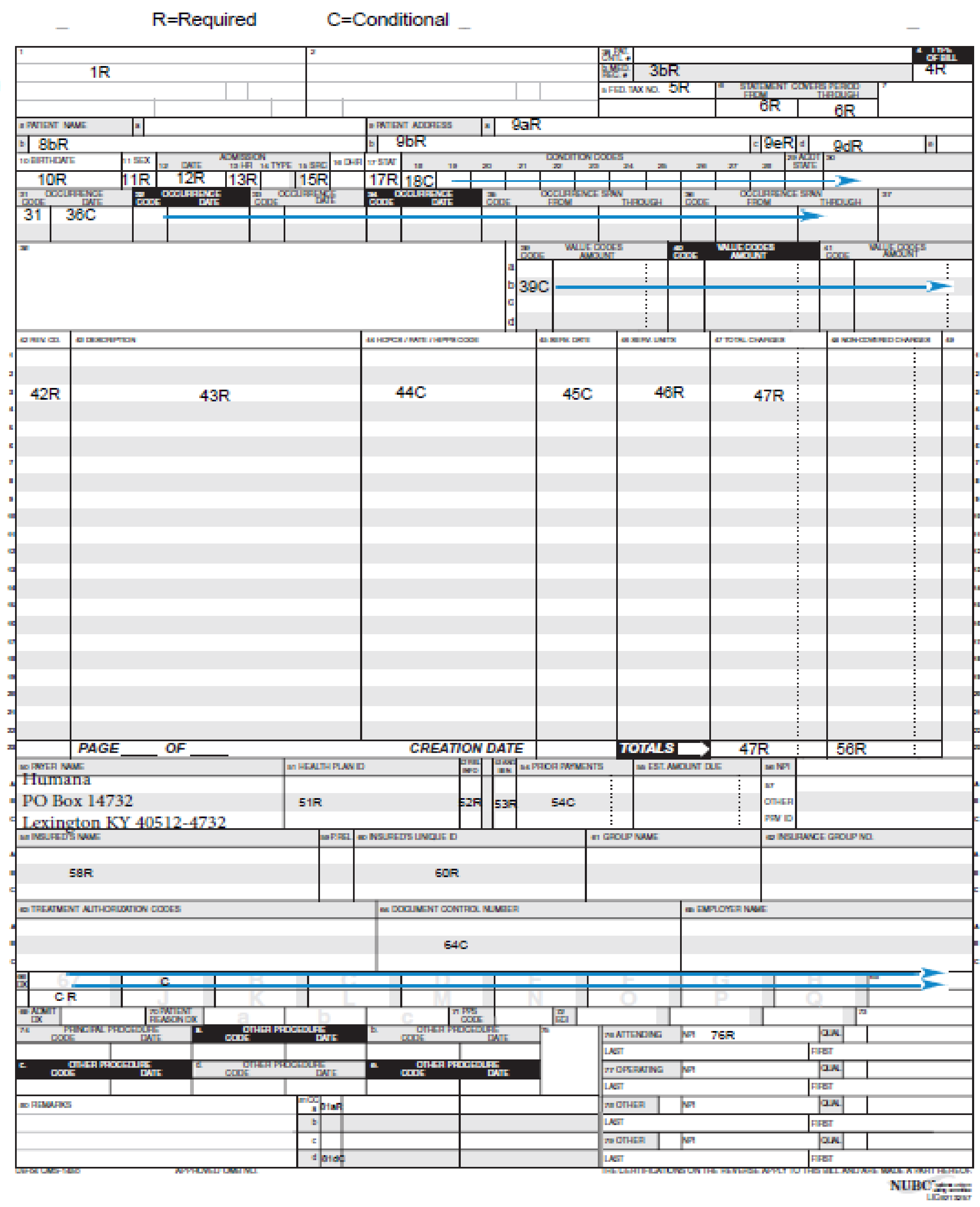
The use of reference books is critically important when billing claims. Below is a list of several documents that a billing department should have. These books can be purchased at a nominal fee from most online bookstores.

- Current Procedural Terminology (CPT) Professional Edition codebook
- Healthcare Common Procedure Coding System (HCPCS) codebook
- ICD-10-CM Codebook
- National Uniform Billing Committee Official UB-04 Data Specifications Manual

The most common billing errors are caused by use of improper revenue/HCPCS codes, type of bill, patient disposition (discharge status), occurrence coding (code and date span) and value codes. This document will assist you in accurately completing a nursing home UB-04 claim and facilitate accurate and timely payment of your claims.

## UB-04 REQUIRED VS. CONDITIONAL FIELDS

For health care providers billing on the UB-04/CMS-1450 form, we have included instructions on how to properly complete and submit the paper form. Below is a labeled version of the form and the corresponding key.



R=Required C=Conditional

1R
3bR
4R
5R
6R 6R
8bR
9aR
9bR
9eR 9dR
10R 11R 12R 13R 15R 17R 18C
31 36C
39C
42R 43R 44C 45C 46R 47R
PAGE ___ OF ___ CREATION DATE TOTALS 47R 56R
Humana
PO Box 14732
Lexington KY 40512-4732
51R 52R 53R 54C
58R 60R
64C
C R C
76R
01aR
01dC

| Field location | Field label name | Inpatient | Outpatient | Field content explanation or usage detail |
|---|---|---|---|---|
| **1** | Unlabeled | Required | Required | Complete health care provider name, phone number and mailing address. |
| **2** | Unlabeled | Not required | Not required | |
| **3a** | Patient Control Number | Not required | Not required | |
| **3b** | Medical Record Number | Required | Required | Enter facility medical or health record number. |
| **4** | Type of Bill | Required | Required | Enter appropriate three-digit type of bill as specified by the NUBC UB-04 Data Specs Manual (no leading zero). **See the accepted list of codes on Page 20.** |
| **5** | Federal Tax ID Number | Required | Required | Enter the nine-digit number assigned by the federal government for tax-reporting purposes. |
| **6** | Statement Covers Period | Required | Required | Enter the billing period for this statement. |
| **7** | Unlabeled | Not required | Not required | |
| **8a** | Patient Name | Required | Required | Enter patient's last name, first name and middle initial. |
| **8b** | Unlabeled | Not required | Not required | |
| **9a-d** | Patient Address | Required (except line e) | Required (except line e) | Enter the complete mailing address of the patient:<br>a: Street address<br>b: City<br>c: State<br>d: ZIP code<br>e: Not required |
| **10** | Patient Date of Birth | Required | Required | Enter DOB as (MMDDYYYY). |
| **11** | Patient's Sex | Required | Required | Enter sex as M or F only. |
| **12** | Admission Date | Required | Required | Enter date of admission as (MMDDYYYY). |
| **13** | Admission Hour | Required | Required | Enter hour of admission using two-digit 24 military time (e.g., for 1:00-1:59 a.m., use 01; for 1:00-1:59 p.m., use 13; for 11:00-11:59 a.m., use 11; for 11:00-11:59 p.m., use 23). |
| **14** | Admission Type | Not required | Not required | |

| Field location | Field label name | Inpatient | Outpatient | Field content explanation or usage detail |
|---|---|---|---|---|
| **15** | Admission Source | Required | Required | Enter one-digit code indicating the source of admission:<br>1 - Physician referral<br>2 - Clinic referral<br>4 - Transfer from hospital<br>6 - Transfer from another health care facility<br>7 - Emergency room<br>8 - Court enforced<br>9 - Information not available |
| **16** | Discharge Hour | Not required | Conditional | |
| **17** | Discharge Status | Required | Conditional | A list of discharge statuses can be found in the NUBC UB-04 Data Specs Manual. |
| **18-28** | Condition Codes | Conditional | Conditional | Required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. For a list of codes and additional instructions, refer to the NUBC UB-04 Data Specs Manual. |
| **29** | Accident State | Not required | Conditional | |
| **30** | Unlabeled | Not required | Conditional | |
| **31-34** | Occurrence Codes | Conditional | Conditional | Occurrence codes are typically used when there is a coordination of benefits. For a list of codes and additional instructions, refer to the NUBC UB-04 Data Specs Manual. |
| **35-36** | Occurrence Span Code | Conditional | Conditional | Occurrence span codes are typically used when there is a coordination of benefits. Additional instructions can be found in the NUBC UB-04 Data Specs Manual. |
| **37** | Unlabeled | Not required | Conditional | |
| **38** | Responsible Party | Not required | Conditional | |

| Field location | Field label name | Inpatient | Outpatient | Field content explanation or usage detail |
|---|---|---|---|---|
| **39-41** | Patient Responsibility | Required | Conditional | When patient responsibility is zero (0), enter value code 80 in box 39.<br><br>To report patient responsibility, enter value code 31 in box 39 and the value amount in the adjacent cells.<br><br>This field is only required when reporting covered or noncovered days.<br><br>**Covered Days Value Code:**<br>31 - Patient responsibility<br>80 - Covered days<br>81 - Noncovered days<br><br>**Value Amount**<br>Enter the number of covered or noncovered days in adjacent cells. |
| **42** | Revenue Code | Required | Conditional | Enter the appropriate four-digit revenue code. A list of accepted codes is provided later in this section. |
| **43** | Revenue Code Description | Required | Conditional | A list of accepted descriptions is provided later in this section. |
| **44** | HCPCS/Rates | Conditional | Conditional | Not required for inpatient nursing home claims. |
| **45** | Service Date | Conditional | Conditional | Not required for inpatient nursing home claims. |
| **46** | Service Units | Required | Conditional | Enter number of units/days/visits. |
| **47** | Total Charges | Required | Conditional | Enter total charges for each service line. |
| **48** | Noncovered Charges | Not required | Not required | |
| **49** | Unlabeled | Not required | Not required | |
| **50a-c** | Payer | Required | Required | Enter all appropriate payers.<br>**Note: Humana is the payer for LTSS Humana Gold Plus Integrated claims.** |

| Field location | Field label name | Inpatient | Outpatient | Field content explanation or usage detail |
|---|---|---|---|---|
| **51** | Health Plan ID Number | Required | Required | Enter appropriate payer ID for each of the corresponding payers listed in Field 50. **Note: Humana is the payer for LTSS Humana Gold Plus Integrated claims. Use only payer ID 61115.** |
| **52a-c** | REL INFO | Required | Required | Release information is required for every payer **(must be Y)**. |
| **53** | ASG BEN | Conditional | Conditional | Occurrence codes are typically used when there is a coordination of benefits. For a list of codes and additional instructions, refer to the NUBC UB-04 Data Specs Manual. |
| **54** | Prior Payments | Conditional | Conditional | Used for coordination of benefits. |
| **55** | EST Due AMT | Not required | Not required | |
| **56** | NPI | Required | Required | Enter the health care provider's 10-character NPI number. |
| **57** | Other Provider ID | Not required | Not required | |
| **58** | Insured's Name | Required | Required | Enter the name of the person who carries the insurance policy. |
| **59** | Patient Relationship | Not required | Not required | |
| **60** | Insured's Unique ID | Required | Required | Enter the patient's insurance ID number.** |
| **61** | Group Name | Not required | Not required | |
| **62** | Insurance Group Number | Not required | Not required | |
| **63** | Treatment Authorization Codes | Not required | Not required | |
| **64** | Document Control Number | Conditional | Conditional | |
| **65** | Employer Name | Not required | Not required | |
| **66** | Diagnosis Code Qualifier | Not required | Not required | Required to indicate the version submitted:<br><br>0 = ICD-10 |
| **67a-q** | Other Diagnosis Codes | Conditional | Conditional | Usually does not apply to nursing home claims. |
| **68** | Unlabeled | Not required | Not required | |
| **69** | Admitting Diagnosis Code | Required | Required | Enter the diagnosis code the patient had at the time of admission. |

| Field location | Field label name | Inpatient | Outpatient | Field content explanation or usage detail |
|---|---|---|---|---|
| **70** | Patient Reason Code | Not required | Not required | |
| **71** | PPS/DRG Code | Not required | Not required | |
| **72** | External Cause Code | Not required | Not required | |
| **73** | Unlabeled | Not required | Not required | |
| **74** | Principal Procedure Code/ Date | Not required | Not required | |
| **75** | Unlabeled | Not required | Not required | |
| **76** | Attending Physician | Required | Required | |
| **77** | Operating Physician | Not required | Not required | |
| **78-79** | Other Physician | Not required | Not required | |
| **80** | Remarks | Not required | Not required | |
| **81a** | Code to Code | Required | Required | Taxonomy number of billing health care provider. |
| **81d** | Level of Care | Not required | Not required | Use this field to indicate level of care. Refer to the level-of-care-codes table in this guide or to the NUBC UB-04 Data Specs Manual, pages 1–48. |

****Note: Insert the Humana-plan-issued member ID.**

## NURSING HOME TYPE OF BILL CODES

Medicaid has expanded the number of the type of bill codes that are valid for nursing facility providers. The table below contains a list of the valid nursing facility type of bill codes according to provider type.

| Nursing facility provider types #9 (hospital-based skilled unit) and #10 (nursing facility) | | |
|---|---|---|
| **21X** | Skilled Nursing Inpatient | Skilled nursing facility<br>Date of admission: the same as the first date of service<br>Date of discharge: the same as the last date of service |
| **211** | Skilled Nursing Admit-Through-Discharge | Skilled nursing admit-through-discharge |
| **213** | Skilled Nursing Interim Continuing Claim | Skilled nursing interim continuing claim |
| **214** | Skilled Nursing Final Claim | Skilled nursing final claim |
| **215** | Skilled Nursing Late Charges-Only Claim | Late charges-only claim |
| **217** | Skilled Nursing Replacement of Prior Claim | Skilled nursing replacement of prior claim |
| **218** | Skilled Nursing Void/Cancel of Prior Claims | Skilled nursing void/cancel of prior claim |

**Effective July 1, 2017, Humana requires prior authorization for specialized nursing care in order to ensure compliance with Virginia Department of Medical Assistance Services (DMAS) Nursing Facility Provider Manual requirements.** Facilities can obtain a prior authorization through the Humana member's assigned care coordinator. If you need assistance reaching the Humana member's assigned care coordinator, please contact the long-term services and supports (LTSS) authorization support team at 1-800-559-3581, option 5, or fax your request to 1-866-202-7609.

As a reminder, to submit a claim for this service, the facility claim must reflect type of bill 65x with revenue (REV) code 0120 and resource utilization groups (RUGs).

To facilitate the timely payment of your claims, please obtain a prior authorization and submit claims in the correct format, as indicated above.

## LEVEL OF CARE CODES

For Field 81d, long-term care facilities [skilled nursing facilities and intermediate care facility/developmentally disabled (ICF/DDs)] need to:

- In the first field, enter qualifier code 02.
- In the second field, enter the established level of care (LOC) code to indicate the type of care that the recipient has been determined to require.
- In the third field, enter the facilities per diem. For level of care X, enter the respective Medicare per diem.

| Level of care codes | Code explanation |
|---|---|
| In the second field, enter the established level of care (LOC) code to indicate the type of care that the recipient has been determined to require: | |
| **1** | Skilled |
| **2** | Intermediate I |
| **3** | Intermediate II |
| **4** | State Mental Health Hospital |
| **6 through 9** | ICF-DD Levels of Care |
| **H** | AIDS Per Diem |
| **U** | Skilled Fragile Children Under 21 |
| **X** | Medicare Part A Coinsurance Payment |

## REVENUE CODES ROOM AND BOARD

**Long-term care facilities (skilled nursing facilities and ICF/DDs) claims:** Enter the appropriate revenue code:

| Code | Description |
|---|---|
| **0190** | **Subacute Care**<br>(Use for intermediate care/custodial claims) |
| **0185** | **Hospital Leave Days**<br>(Bed-hold days) |
| **0183** | **Leave of Absence – Therapeutic Leave** |
| **0182** | **Home Leave Days**<br>(Therapeutic bed-hold days) |
| **0022** | **SNF Distinct Billing Period**<br>In addition to billing the revenue codes for room and board and ancillary services, each nursing facility claim must contain one revenue code "0022" for each distinct billing period of the nursing facility stay. The Resource Utilization Group (RUG) code determined by the RUG-III, 34 grouper must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment should be reported in the last two digits of the HIPPS rate code. The total charges for revenue code 0022 should be zero. |

## UB-04 PATIENT DISPOSITION CODES (DISCHARGE STATUS)

This field must contain the code indicating the patient's status as of the ending service date of the period covered-through date on the bill.

| Code | Description |
|---|---|
| **01** | Discharged/Transferred to Home or Self Care (Routine Discharge) |
| **02** | Discharged/Transferred to Another Short-term Hospital for Inpatient Care |
| **03** | Discharged/Transferred to a Skilled Nursing Facility (SNF) |
| **04** | Discharged/Transferred to an Intermediate Care Facility (ICF) |
| **05** | Discharged/Transferred to a Designated Cancer Center or Children's Hospital |
| **06** | Discharged/Transferred to Home Under Care or Organized Home Health Services |
| **07** | Left Against Medical Advice or Discontinued Care |
| **08** | Reserved for National Assignment |
| **10-14** | Reserved for National Assignment |
| **15** | Planned Acute Care Hospital Inpatient |
| **16-19** | Reserved for National Assignment |
| **20** | Expired |
| **21** | Discharged/Transferred to Court/Law Enforcement |
| **22-29** | Reserved for National Assignment |
| **30** | Still Patient |
| **31-39** | Reserved for National Assignment |
| **43** | Discharged/Transferred to Federal Assignment |
| **44-49** | Reserved for National Assignment |
| **50** | Hospice-Home |
| **51** | Hospice-Medical Facility |
| **52-60** | Reserved for National Assignment |
| **61** | Discharged/Transferred Within This Institution to Hospital-based, Medicare-approved Swing Bed |
| **62** | Discharged/Transferred to Inpatient Rehabilitation Facility (IRF) including District Part Units of Hospital (Effective Retroactive to 1/1/2000) |
| **63** | Discharged/Transferred to Medicare-certified Long-term-care Hospital (LTCH) |
| **64** | Discharged/Transferred to a Nursing Facility Under Medicaid, but Not Certified Under Medicare |
| **65** | Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital |
| **66** | Discharged/Transferred to a Critical Access Hospital (CAH) |
| **67-68** | Reserved for National Assignment |
| **69** | Discharged/Transferred to a Designated Disaster Alternate Care |
| **70** | Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere |
| **81** | Discharged to Home or Self Care With a Planned Acute Care Hospital Inpatient Readmission |
| **82** | Discharged/Transferred to Short-term General Hospital for Inpatient Care With a Planned Acute Hospital Readmission |

| Code | Description |
|---|---|
| **83** | Discharged/Transferred to a Skilled Nursing Facility (SNF) With Medicare Certification With a Planned Acute Hospital Readmission |
| **84** | Discharged/Transferred to a Facility That Provides Custodial or Supportive Care With a Planned Acute Hospital Inpatient Readmission |
| **85** | Discharged/Transferred to a Designated Cancer Center or Children's Hospital With a Planned Acute Hospital Inpatient Readmission |
| **86** | Discharged/Transferred to Home Under Care of Organized Home Health Service Organization With a Planned Acute Hospital |
| **87** | Discharged/Transferred to Court/Law Enforcement With a Planned Acute Hospital Inpatient Readmission |
| **88** | Discharged/Transferred to a Federal Health Care Facility With a Planned Acute Hospital Inpatient Readmission |
| **89** | Discharged/Transferred to a Hospital-based, Medicare-approved Swing Bed With a Planned Acute Hospital Inpatient Readmission |
| **90** | Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital With a Planned Acute Hospital Inpatient Readmission |
| **91** | Discharged/Transferred to a Medicare-certified Long-term-care Hospital (LTCH) With a Planned Acute Hospital Inpatient Readmission |
| **92** | Discharged/Transferred to a Nursing Facility Certified Under Medicaid, but Not Certified Under Medicare With a Planned Acute Hospital Inpatient Readmission |
| **93** | Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital With a Planned Acute Hospital Inpatient Readmission |
| **94** | Discharged/Transferred to a Critical Access Hospital (CAH) With a Planned Acute Hospital Inpatient Readmission |
| **95** | Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List With a Planned Acute Hospital Inpatient Readmission |

## OCCURRENCE CODES

| Code | Description | Guidelines |
|---|---|---|
| **1** | Automobile accident/auto liability insurance involved | Enter the date of the auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault. |
| **2** | Auto or other accident/no fault involved | Enter the date of the accident including auto or other where no-fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50 or 51 to document coordination of benefits with the no-fault insurer. |
| **3** | Accident/tort liability | Enter the date of an accident (excluding auto) resulting from a third party's action. This incident may involve a civil court action in an attempt to require payment by the third party other than no-fault liability.<br>Refer to subsection 4.13.6, "Third Party Liability - Tort" in section 4, "Client Eligibility" (Vol. 1, General Information). |
| **4** | Accident/employment related | Enter the date of an accident that allegedly relates to the patient's employment and involves compensation or employer liability. Use this code in conjunction with occurrence codes 24, 50 or 51 to document coordination of benefits with workers' compensation insurance or an employer. Only services not covered by workers' compensation may be considered for payment by Medicaid. |
| **5** | Other accident | Enter the date of an accident not described by the above codes. Use this code to report no other casualty-related payers have been determined. |
| **6** | Crime victim | Enter the date on which a medical condition resulted from alleged criminal action. |
| **10** | Last menstrual period | Enter the date of the last menstrual period when the service is maternity-related. |
| **11** | Onset of symptoms | Indicate the date the patient first became aware of the symptoms or illness being treated. |
| **16** | Date of last therapy | Indicate the last day of therapy services for occupational therapy (OT), physical therapy (PT) or speech therapy (ST). |
| **17** | Date outpatient OT plan established or last reviewed | Indicate the date a plan was established or last reviewed for OT. |
| **24** | Date other insurance denied | Enter the date of denial coverage by a third-party resource (TPR). |
| **25** | Date benefits terminated by primary payer | Enter the last date for which benefits are being claimed. |
| **27** | Date home health plan of treatment was established | Enter the date the current plan of treatment was established. |
| **29** | Date outpatient PT plan established or last reviewed | Indicate the date a plan of treatment was established or last reviewed for PT. |

| Code | Description | Guidelines |
|---|---|---|
| **30** | Date outpatient speech pathology plan established or last reviewed | Indicate the date a plan of treatment for speech pathology was establish or last reviewed. |
| **35** | Date treatment started for PT | Indicate the date services were initiated for PT. |
| **44** | Date treatment started for OT | Indicate when OT services were initiated. |
| **45** | Date treatment started for speech language pathology (SLP) | Indicate when SLP services were initiated. |
| **50** | Date other insurance paid | Indicate the date the other insurance paid the claim. |
| **51** | Date claim filed with other insurance | Indicate the date the claim was filed to the other insurance. |
| **52** | Date renal dialysis initiated | Indicate the date renal dialysis was initiated. |

Humana requests the 837 INSTITUTIONAL file be submitted with the following values:
Loop 2000B Subscriber Hierarchical Level

If you submit a group or policy number in the SBR03 segment, the SBR04 is SITUATIONAL. If sent, the Plan Name should contain the word "MEDICAID" only and the SBR09 should contain "MC" for Medicaid.

**Preferred submission example:** SBR✻P✻✻GRP01020102✻MEDICAID✻✻✻✻MC~

## 837I MAPPING OF REQUIRED FIELDS

Below are the required fields for successfully transmitting 837I batch claims.

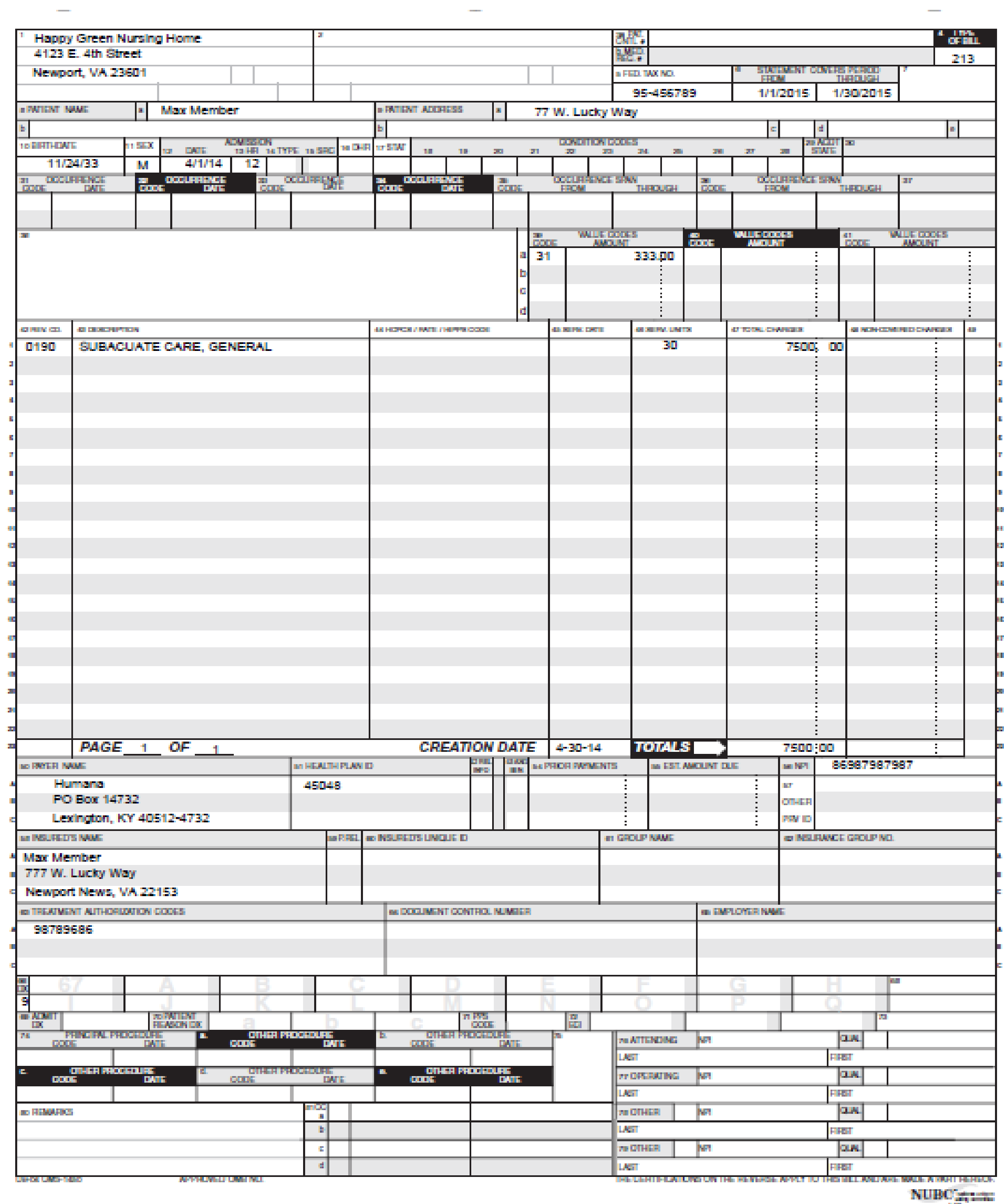
| **837I Mapping (required fields)** | |
|---|---|
| **FIELD NAME** | **LOOP/SEGMENT** |
| PROVIDER_NAME | NM1-2010AA |
| PROVIDER_STREET | N3-2010AA |
| PROVIDER_CITY | N4-2010AA |
| PROVIDER_STATE | N4-2010AA |
| PROVIDER_ZIP | N4-2010AA |
| PAY_TO_STATE | N4-2010AB |
| PAY_TO_ZIP | N4-2010AB |
| TYPE_OF_BILL | CLM05-2300 |
| FEDERAL_TAX_NUMBER | REF-2010AA |
| NATIONAL PROVIDER IDENTIFIER_QUALIFIER | NM108-2010AA |
| NATIONAL PROVIDER INDENTIFIER_VALUE | NM109-2010AA |
| PATIENT_NAME | NM1-2010CA |
| PATIENT_NAME_LAST | NM1-2010CA |
| PATIENT_NAME_FIRST | NM1-2010CA |
| PATIENT_STATE | N4-2010CA |
| PATIENT_ZIP | N4-2010CA |
| PATIENT_BIRTH_DATE | DMG02-2010BA |
| ADMISSION_TYPE | CL1-2300 |
| ADMISSION_SOURCE | CL1-2300 |
| PRINCIPAL_DIAGNOSIS | HI-2300 |
| INSURED_ID | NM1-2010BA |
| REV_CODE | SV2-2400 |
| TOTAL_SUBMITTED_CHARGES | CLM02 - 2300 |
| ADMISSION_DATE | CLM01 - 2300 |

For further information on how to transmit batch claims, consult the X12 Institutional and Professional Claim Standard Companion Guide at https://www.availity.com/documents/edi%20guide/edi_guide.pdf.

Providers can submit claims through Direct Data Entry on the Availity portal at www.availity.com. Availity offers a free web tool for health care providers to upload batch claims electronically. The following requirements should be met:

- Health care providers must register for a user account on www.availity.com.
- Health care providers should have claims software with EDI file creation capabilities.

## EXAMPLE OF A CLEAN UB-04 FORM



1 Happy Green Nursing Home
4123 E. 4th Street
Newport, VA 23601

3a PAT. CNTL # | b. MED. REC. #

4 TYPE OF BILL: 213

5 FED. TAX NO.: 95-456789

6 STATEMENT COVERS PERIOD FROM: 1/1/2015 THROUGH: 1/30/2015

8 PATIENT NAME: Max Member

9 PATIENT ADDRESS: 77 W. Lucky Way

10 BIRTHDATE: 11/24/33 | 11 SEX: M | ADMISSION 12 DATE: 4/1/14 | 13 HR: 12 | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18–28 | 29 ACDT STATE | 30

31–34 OCCURRENCE CODE / DATE | 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37

38

39–41 VALUE CODES CODE / AMOUNT: a 31 | 333.00

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0190 | SUBACUATE CARE, GENERAL | | | 30 | 7500 00 | | |
| | PAGE 1 OF 1 | CREATION DATE | 4-30-14 | TOTALS | 7500 00 | | |

50 PAYER NAME: Humana, PO Box 14732, Lexington, KY 40512-4732

51 HEALTH PLAN ID: 45048

52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE

56 NPI: 86987987987

57 OTHER PRV ID

58 INSURED'S NAME: Max Member, 777 W. Lucky Way, Newport News, VA 22153

59 P.REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES: 98789686

64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A B C D E F G H | I J K L M N O P Q | 68

69 ADMIT DX | 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 | c. OTHER PROCEDURE CODE / DATE | d. OTHER PROCEDURE CODE / DATE | e. OTHER PROCEDURE CODE / DATE | 75

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81 CC a b c d

UB-04 CMS-1450 | APPROVED OMB NO. | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC LIC9213257

# BILLING CODES BY SERVICE TYPE

| Elderly or Disabled With Consumer Direction Waiver | | | | |
|---|---|---|---|---|
| **National code** | **Location** | **Modifier** | **Code description** | **Rates effective 7/1/2017** |
| **99199*** | | U4 | Environmental Modification, Maintenance Costs Only | |
| **99509** | NOVA | U9 | Service Facilitation Routine Visit | $72.41 |
| **99509** | ROS | | Service Facilitation Routine Visit | $55.69 |
| **A0120** | NOVA | U9 | Adult Day Health Care (per trip) | $1.98 |
| **A0120** | ROS | | Adult Day Health Care | $1.98 |
| **H2000** | NOVA | U9 | Service Facilitation Initial Comprehensive Visit | $232.78 |
| **H2000** | ROS | | Service Facilitation Initial Comprehensive Visit | $179.33 |
| **H2015** | | | Transition Coordination | $323.24 |
| **H2021** | NOVA | TD, U9 | PERS Nursing Services/RN | $14.85 |
| **H2021** | ROS | TD | PERS Nursing Services/RN | $12.13 |
| **H2021** | NOVA | TE, U9 | PERS Nursing Services/LPN | $12.87 |
| **H2021** | ROS | TE | PERS Nursing Services/LPN | $10.15 |
| **S5102** | NOVA | U9 | Adult Day Health Care | $61.60 |
| **S5102** | ROS | | Adult Day Health Care | $57.04 |
| **S5109** | NOVA | U9 | Service Facilitation Consumer Training Visit | $231.67 |
| **S5109** | ROS | | Service Facilitation Consumer Training Visit | $178.21 |
| **S5116** | NOVA | U9 | Service Facilitation Management Training Hours | $28.96 |
| **S5116** | ROS | | Service Facilitation Management Training Hours | $22.28 |
| **S5126** | NOVA | U9 | Consumer-Directed Personal Assistance/Attendant Care | $11.93 |
| **S5126** | ROS | | Consumer-Directed Personal Assistance/Attendant Care | $9.22 |
| **S5150** | NOVA | U9 | Consumer-Directed Respite Services | $11.93 |
| **S5150** | ROS | | Consumer-Directed Respite Services | $9.22 |
| **S5160** | NOVA | U9 | PERS Installation | $58.41 |
| **S5160** | ROS | | PERS Installation | $49.50 |
| **S5160** | NOVA | U1, U9 | PERS Installation and Medication Monitoring | $87.62 |
| **S5160** | ROS | U1 | PERS Installation and Medication Monitoring | $74.25 |
| **S5160** | NOVA | U9 | PERS Monitoring | $35.05 |
| **S5161** | ROS | | PERS Monitoring | $29.70 |
| **G9004** | | | Pest Control-Initial | IC |
| **G9005** | | | Pest Control-Maintenance | IC |

| Elderly or Disabled With Consumer Direction Waiver | | | | |
|---|---|---|---|---|
| **National code** | **Location** | **Modifier** | **Code description** | **Rates effective 7/1/2017** |
| **S5165*** | | | Environmental Modifications Only | IC |
| **S5185** | NOVA | U9 | PERS Medication Monitoring | $58.41 |
| **S5185** | ROS | | PERS Medication Monitoring | $49.50 |
| **S9125** | NOVA | TE, U9 | Respite Care LPN | $31.97 |
| **S9125** | ROS | TE | Respite Care LPN | $26.37 |
| **T1005** | NOVA | U9 | Respite Care | $15.81 |
| **T1005** | ROS | | Respite Care | $13.43 |
| **T1019** | NOVA | U9 | Personal Care | $15.81 |
| **T1019** | ROS | | Personal Care | $13.43 |
| **T1028** | NOVA | U9 | Service Facilitation Reassessment Visit | $116.96 |
| **T1028** | ROS | | Service Facilitation Reassessment Visit | $89.11 |
| **T1999**** | | | Assistive Technology Only | IC |
| **T1999**** | | U5 | Assistive Technology, Maintenance Costs Only | IC |
| **T2038***** | | | Transition Services | IC |

*IC = Individual Consideration*
*CD = Consumer Directed*
*NOVA = Northern Virginia*
*ROS = Rest of State*

**Costs are limited to $5,000 per calendar year for both codes combined under environmental modifications and only apply to money-follows-the-person (MFP) participants.*

***Costs are limited to $5,000 per calendar year for both codes combined under assistive technology and only apply to MFP participants.*

****Available within the first 30 days of transition to a qualified residence. Costs are limited to a one-time cost of $5,000 and only apply to MFP participants.*

*****For claims with dates of service (DOS) Jan. 1, 2017, and onward, LTSS providers need to follow the tips below for claims submission:**

- We encourage LTSS providers to submit claims electronically using Availity. Please register at www.availity.com and enjoy the many benefits. If you have general Availity questions or need technical assistance, please call Availity Client Services at 1-800-282-4548, or you can open a support ticket via the Availity Portal Account. Once logged in, click “Help & Training” and then “My Support Tickets.”
- Bill one date at a time. **(See Page 11; 24a)** = “Enter the date of service for each procedure, service or supply on an individual line”

- If you are billing a corrected claim, please make sure you use the original dates that were submitted and simply correct the dates/units or modifier (if applicable). Please **enter "7"** in **box 22** for a corrected claim **(See Page 10)**.
- Span billing is allowed only for nursing facilities; however, span billing **across months** is not allowed.
- The following taxonomy codes are required for claims for the below LTSS services:
  - **Intermediate Nursing Home Facility – 313M00000X**
  - **Skilled Nursing Home Facility – 314000000X**
- Please include the NPI in the applicable section of the paper and electronic claim form. Failure to do so will result in a claim denial.
- If you have claim questions or issues, please contact us at 1-855-280-4002.

# NOTES