Assisted Living Centers

Billing on a CMS 1500 Claim Form

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Overview

- **Effective for dates of service on or after February 1, 2018** Assisted Living Center providers must begin billing on the CMS 1500 claim form in place of the UB-04 claim form.

- The goal of this webinar is to explain the reason for this change and educate providers on how to bill utilizing the CMS 1500 claim form.

Reasons for Change

- This change is due to recent updates to Federal requirements for UB-04 claim submissions.
- This will result in positive changes for providers:
    1) Eliminates Federal requirement for referring physician's NPI
    2) Result in more efficient claims processing
    3) Separate, updated Assisted Living billing manual developed to assist providers in the claims process
    4) Non-institutional claim form aligns with state and federal initiatives

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- **Block 1**: Select Medicaid by placing an X in the open area to the right
- **Block 1A** INSURED'S ID NO. (MANDATORY):
  - The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.

Billing on a CMS 1500 cont.

- **Block 2** PATIENT'S NAME (MANDATORY):
  - Enter the recipient's last name, first name and middle initial
- **Block 21** DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (MANDATORY):
  - Enter 0 for the ICD-10-CM indicator
  - Enter the codes on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code

Billing on a CMS 1500 cont.

- **Block 22** RESUBMISSION CODE (only used for claim adjustment or void):
  - Enter a 7 for an Adjustment; or an 8 for a Void
  - List the original reference number found on your remittance advice. This number will always be 14 digits.
    - Note: You cannot void or adjust one line on the claim. The void or adjustment will apply to the entire claim.

Billing on a CMS 1500 cont.

- **Block 24**: Use a separate line for each date span. If billing on paper and more than six date spans were provided in a single calendar month then a separate claim from for the seventh and following service must be completed; continued claims are not accepted.
- **Hospital Reserve Bed Days and Therapeutic Leave Days**
  - Important clarifications have been made regarding how to bill Hospital Reserve Bed Days and Therapeutic Leave Days in block 24 on the CMS 1500 claim form
  - Refer to the Assisted Living Billing Manual for specific instructions

Billing on a CMS 1500 cont.

- **24A** DATE OF SERVICE FROM – TO (MANDATORY):
  - Enter the appropriate date of service in month, day and year sequence, using six digits in the unshaded portion.
    - Example: From: 100117 To: 103117
  - Hospital Reserve Bed Days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five consecutive days when a recipient is admitted to an inpatient hospital stay. Up to five consecutive days may be billed to SD Medicaid per hospitalization; however, the recipient must return to the ALC for a minimum of 24 hours before additional hospital reserve be days will be paid. ***Hospital reserve bed days must be billed with a code 21 in 24B for the place of service***

Billing on a CMS 1500 cont.

- Therapeutic leave days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five therapeutic leave days per month. Therapeutic leave days may be consecutive or non-consecutive. Therapeutic leave days are leave days from the Assisted Living Center for non-medical reason (e.g., visits to the homes of family or friends). ***Therapeutic leave days must be billed with a code 12 in 24B for the place of service***
- Do not include the recipient's date of discharge or death in the dates of service

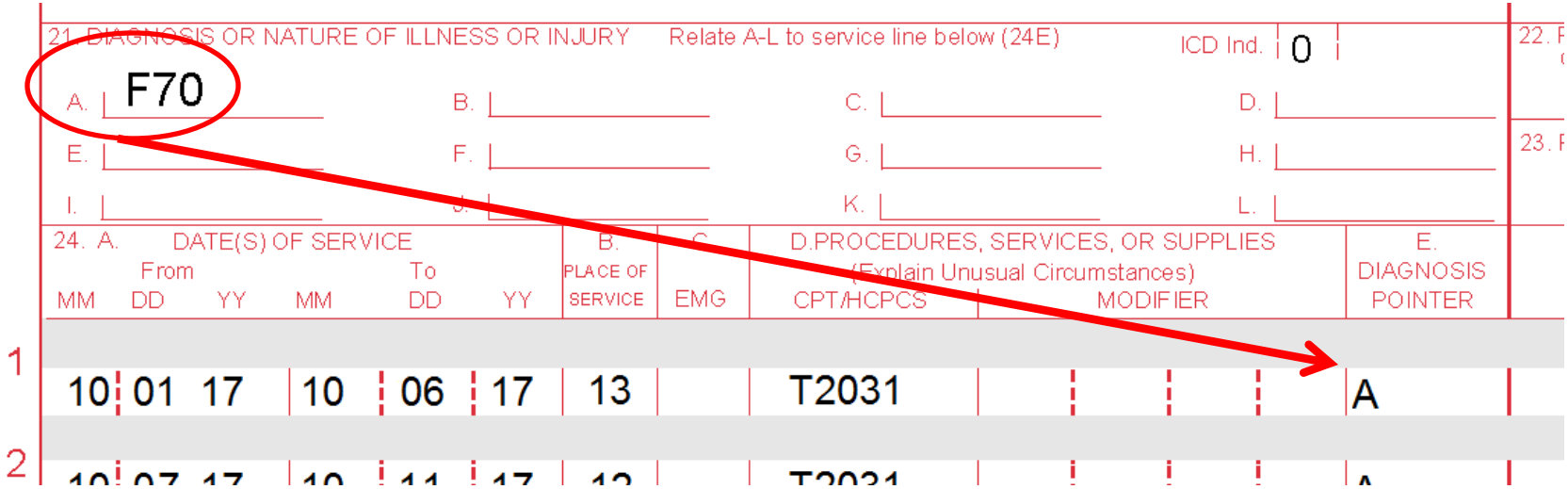
Billing on a CMS 1500 cont.

- **24B** PLACE OF SERVICE (MANDATORY):
  - Enter the appropriate place of service code
  - Code Value:
    - 12 Home (Therapeutic Leave)
    - 13 Assisted Living Center
    - 21 In-Patient Hospital (Hospital Reserve Days)
- **24D** PROCEDURE CODE (MANDATORY):
  - Enter the appropriate five character Healthcare Common Procedure Coding System (HCPCS) code for the approved service provided
  - **T2031 – Assisted Living**

Billing on a CMS 1500 cont.

- **24E** DIAGNOSIS POINTER (MANDATORY):
  - Enter A – L which correlates to the diagnosis code entered in block 21
  - You will receive this diagnosis code from the admitting physician
  - See next slide for clarification

Billing on a CMS 1500 cont.



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY — Relate A-L to service line below (24E) — ICD Ind. 0

A. F70 B. C. D.

E. F. G. H.

I. J. K. L.

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
1	10	01	17	10	06	17	13		T2031				A
2	10	07	17	10	11	17	12		T2031				A

Notice, field E has an A, this is the corresponding diagnosis code for this claim line.

Billing on a CMS 1500 cont.

- **24F** CHARGES (MANDATORY):
  - Enter the provider's usual and customary charge for this service in the unshaded portion. For example, if the usual and customary charge is $50.00 enter 50.00
- **24G** DAYS OR UNITS (MANDATORY):
  - Enter the number of days that the service was provided for this recipient during the period covered by the dates in block 24A. The units must equal the date of service span.
    - From 100717 to 101117 = 5 days (units)

Billing on a CMS 1500 cont.

- **24I** ID QUALIFIER (MANDATORY):
  - Enter ZZ
- **24J** TAXONOMY AND RENDERING PROVIDER ID# (OPTIONAL):
  - Enter 310400000X
  - Enter the ALC NPI number in the unshaded portion of the field or leave blank. This will be the same NPI that is used in 33A.

Billing on a CMS 1500 cont.

- **Block 25** FEDERAL TAX ID NUMBER (MANDATORY):
  - The number assigned to the provider by the federal government for tax reporting purposes; also so known as a tax identification number (TIN) or employer identification number (EIN).
- **Block 28** TOTAL CHARGES (OPTIONAL)
  - Enter the sum of the charges in column 24F.
- Note: the recipients' cost share will be calculated by South Dakota Medicaid when the claim is submitted. **Do not include the cost share on the claim**

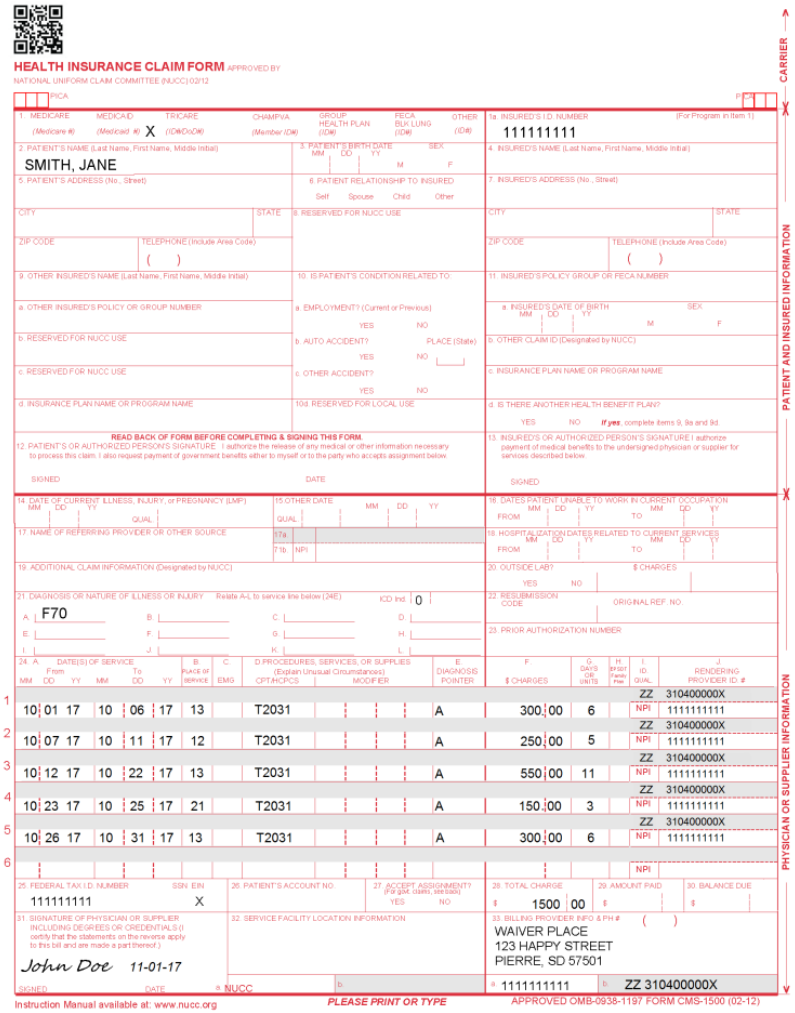
Billing on a CMS 1500 cont.

- **Block 31** SIGNATURE (MANDATORY):
  - The claim must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp or other means. Enter the date that the form was signed. Claims will not be paid without a signature or a date.

Billing on a CMS 1500 cont.

- **Block 33** PROVIDER NAME, ADDRESS AND ZIP CODE (MANDATORY):
  - Enter the billing provider's name and ALC address as shown on the SD MEDX Enrollment record.
    - 33A (MANDATORY) Enter the billing NPI number of the ALC
    - 33B (MANDATORY) enter ZZ310400000X with no spaces.

Example CMS 1500 claim form



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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 111111111

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

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) ( )

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

ZIP CODE | TELEPHONE (Include Area Code) ( )

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? PLACE (State) YES NO

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

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

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

15. OTHER DATE MM DD YY | QUAL.

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. 0

A. F70 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	10 01 17	10 06 17	13		T2031		A	300 00	6		ZZ NPI	310400000X 1111111111
2	10 07 17	10 11 17	12		T2031		A	250 00	5		ZZ NPI	310400000X 1111111111
3	10 12 17	10 22 17	13		T2031		A	550 00	11		ZZ NPI	310400000X 1111111111
4	10 23 17	10 25 17	21		T2031		A	150 00	3		ZZ NPI	310400000X 1111111111
5	10 26 17	10 31 17	13		T2031		A	300 00	6		ZZ NPI	310400000X 1111111111
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 111111111 X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1500 00

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.)

John Doe 11-01-17

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NUCC | b.

33. BILLING PROVIDER INFO & PH # ( )

WAIVER PLACE
123 HAPPY STREET
PIERRE, SD 57501

a. 1111111111 | b. ZZ 310400000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

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Next Steps

- Assisted Living providers should
  - Contact the Division of Long Term Services and Supports with questions/concerns regarding claims submission on the CMS 1500
  - Update billing software (preference) and/or order CMS 1500 claim forms
  - Participate in testing during the month of January 2018

Resources

- Rates are paid at the rate calculated by DHS Budget & Finance.
- Failure to properly complete MANDATORY requirements will cause the claim to be denied by South Dakota Medicaid
- Assisted Living Billing Manual
  - http://dss.sd.gov/docs/medicaid/providers/billingmanuals/assisted_living_manual_1.1.18.pdf
- Guidelines for Submitting Clean Paper Claims
  - Optical Character Recognition Guidelines & Tips http://dss.sd.gov/medicaid/ocr.aspx

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Contacts

- Medicaid Eligibility or Claims Questions
  - 800-452-7691
- Questions specific to the transition from the UB04 to the CMS 1500
  - shannon.schweitzer@state.sd.us
- Questions concerning clearing house, electronic claims submission or taxonomy
  - Chelsea.king@state.sd.us
- Portal Questions
  - dssonlineportal@state.sd.us
- Surveillance and Utilization Review
  - surs@state.sd.us

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