Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Aging and Disability Services Administration
and
Health and Recovery Services
Administration (HRSA)

Nursing Facilities

Billing Instructions

[Chapter 388-96 WAC]

Copyright Disclosure

About this publication

These billing instructions are designed to help nursing facility providers and nursing facility staff understand the Aging and Disability Services Administration's (ADSA) and the Department of Social and Health Service's (DSHS) regulations and requirements necessary for reporting accurate and complete claim information. Refer to Chapter 74.46 RCW (Nursing Facility Medicaid Payment System) and 71A RCW (Developmental Disabilities) for further information.

This publication supersedes all previous ADSA/HRSA Nursing Facilities Billing Instructions published by DSHS/HRSA

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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DSHS/HRSA Billing Instructions and # Memos

To obtain DSHS/HRSA provider numbered memoranda and billing instructions, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

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Important Contacts

A provider may use DSHS's toll-free lines for questions regarding its programs. DSHS's response is based solely on the information provided to the DSHS representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern DSHS's programs.
[WAC 388-502-0020 (2)].

Where do I call for information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?

Aging and Disability Services Administration
1-800-422-3263

Where do I send my hardcopy claims?

Division of Healthcare Services
PO Box 9248
Olympia, WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

Go to the DSHS/HRSA web site at: http://hrsa.dshs.wa.gov, Provider Publications/Fee Schedules link.

Who do I contact if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, or to request billing instructions?

Claims Processing Nursing Facility Case Load* Managers:

A-C	1-360-725-1130
D-G	1-360-725-1081
H-L	1-360-725-1052
M-O	1-360-725-1089
P	1-360-725-1051
Q, R	1-360-725-1054
S	1-360-725-1282
T-Z	1-360-725-1054

*Case loads are based on the first letter of your nursing facility provider name.

What is included in the nursing facility per diem or general rate questions?

Aging and Disability Services Administration
1-800-422-3263

Private insurance or third-party liability?

Coordination of Benefits
1-800-562-6136

Electronic Claims Submission Information?

Affiliated Computer Services (ACS) Hotline for technical testing questions on software or ACS EDI GATEWAY services:

1-800-833-2051

ACS EDI Gateway Inc., web page

http://www.acs-gcro.com

DSHS HIPAA web site for free software and HIPAA-compliance information:

http://hrsa.dshs.wa.gov/dshshipaa

Federal HIPAA-compliance web site with practical advice for providers and the answers to frequently-asked questions (FAQ):

http://www.cms.hhs.gov/HIPAAGenInfo/

How do I obtain DSHS forms?

To **download** DSHS forms, visit DSHS Forms and Records Management Service on the web: http://www.dshs.wa.gov/msa/forms/eforms.html

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

Aging and Disability Services Administration (ADSA) - As a component of the Washington State Department of Social and Health Services, ADSA provides a broad range of social and health services to adult and older persons living in the community and in residential care settings. These services are designed to establish and maintain a comprehensive and coordinated service delivery system which enables persons served to achieve the maximum degree of independence and dignity of which they are capable.

By Report (BR) – A method of reimbursement in which DSHS determines the amount it will pay for a service that is not included in DSHS's published fee schedules. DSHS may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

Chart – A summary of medical records on the individual patient.

Client - An individual who has been determined eligible to receive medical or health care services under any DSHS program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level.

Department - The state Department of Social and Health Services (DSHS).

Division of Developmental Disabilities (DDD) - The division in DSHS responsible for administering and overseeing services for clients with developmental disabilities.

Explanation of Benefits (EOB) – A numeric message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Home and Community Services (HCS) Office – A disabilities and long term care administration office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to adults with functional disabilities.

Hospital – A facility licensed under chapter 70.41 RCW, or comparable health care facility operated by the federal government or located and licensed in another state.

Institutional Award Letter - An official document issued by the local DSHS Home and Community Services (HCS) office or Community Services Office (CSO) which provides information about a nursing facility resident. The information pertains to the DSHS client's income and resources, their medical care eligibility, the effective date for care, the care level, etc.

Institute for Mentally Retarded (IMR) - An IMR facility for DDD is defined as a Title XIX-certified intermediate care facility for persons with mental retardation. These facilities:

- Provide IMR services to eligible clients with mental retardation or related conditions who require intensive habilitation training;
- Provide support services which may best be provided in a 24-hour residential care facility; and
- Meet the standards and guidelines of the federal nursing facility IMR program.

Managed Care – A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either a Managed Care Organization (MCO) or a Primary Care Case Management (PCCM) provider.

Maximum Allowable - The maximum dollar amount that DSHS reimburses a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the Categorically Needy Program or Medically Needy Program.

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has several parts including:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and

supplies not covered under Part A of Medicare. [WAC 388-500-0005]

- "Part C" is the Medicare benefits covered when a client is enrolled in a managed Medicare or Medicare Advantage plan to include physician services, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies not covered under Part A.

- "Part D" is the Medicare prescription drug insurance benefit, covering prescription drugs for a medically accepted indication, biological products, insulin, vaccines, and some medical supplies associated with the injection of insulin.

Nursing Facility (NF) – A home, place, or institution, licensed under chapter 18.51 or 70.41, RCW, where skilled nursing care services are delivered.

Nursing Facility Rates For ADSA Payment - Prospective reimbursement rates as outlined in WAC 388-96-704.

Patient Identification Code (PIC) – An alphanumeric code that is assigned by DSHS to each DSHS client, consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters or characters (dashes, apostrophes) of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Patient Participation - The amount a client is responsible to pay each month toward the total cost of long term care services they receive. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income.

Per Diem Costs - (Per patient day or per resident day) Total allowable costs for a fiscal period divided by total patient or resident days for the same period.

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from DSHS.

Qualified Medicare Beneficiary (QMB) Program – This program pays for Medicare Part A and Part B premiums, and deductibles, coinsurance and copayments, under Part A, Part B, and Part C.

QMB Only – An individual who is eligible for the QMB program but is not eligible for a Categorically Needy (CN) or Medically Needy (MN) Medicaid program.

Record – Dated reports supporting claims submitted to the DSHS for medical services provided in a client's home, a physician's office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of services must be in chronological order by the practitioner who provided the service.

Resident – A person residing in a nursing facility. The term resident excludes outpatients and persons receiving adult day or night care, or respite care.

Revised Code of Washington (RCW) – Washington State law.

Spenddown – The process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department.

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of medical program client.

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual and Customary Charge – The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The established charge that is billed the general public for the same services; or
2) If the general public is not served, the established rate normally offered to other contractors for the same services.

See also WAC 388-502-0100(8).

Washington Administrative Code (WAC) – Codified rules of the state of Washington.

Nursing Facilities

About the Program

The purpose of the Nursing Facilities program is to reimburse for medically necessary nursing facility services provided to Medicaid-eligible clients. The nursing facility billing process for DSHS clients was developed by the Aging and Disability Services Administration (ADSA) and the Health and Recovery Services Administration (HRSA). Refer to Chapter 74.46 RCW (Nursing Facility Medicaid Payment System) and 71A RCW (Developmental Disabilities) for further information.

Client Eligibility

Who is eligible for nursing facility services?

Clients who qualify for benefits under Chapter 388-513 WAC will be issued an Institutional Benefits Award Letter by a HCS office (or the CSO for short stays in a nursing facility – less than 30 days). This award letter qualifies the client for nursing facility services.

Clients who are eligible as a QMB Only client are eligible for payment of Medicare cost sharing expenses under Medicare Part A, Part B, and Part C (except for Part C premiums and Part D costs). Maximum reimbursement under this program is subject to the limits established in WAC 388-502-0110 and WAC 388-517-0320.

Clients who are eligible under this program do not receive an Institutional Award Letter. A QMB Only client can be verified for eligibility by reviewing the following information:

- Medical Identification (ID) card with the words QMB/Medicare Rx.
- DSHS QMB program approval letter.
- WaMedWeb for the QMB program (ACES coverage group S03).

Hospice Clients Who Are Nursing Facility Residents

For information on hospice clients residing in a nursing facility, refer to the current DSHS/HRSA *Hospice Program Billing Instructions* (see **Important Contacts** section to see how to obtain DSHS/HRSA billing instructions).

Reimbursement

DSHS reimburses nursing facilities for costs that are ordinary, necessary, related to the care of medical care recipients, and not expressly unallowable. [RCW 74.46.190 (2)] Refer to RCW 74.46.410 and WAC 388-96-585 for examples of unallowable costs.

Notifying Clients of Their Rights to Make Their Own Healthcare Decisions (Advance Directives) [42 CFR, Subpart I]

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give ***all adult clients*** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Nursing Facility Codes

Patient Class

Enter Value Code 24 with the appropriate Patient Class Code (see table below) in form locator 39-41 on the UB-04 claim form.

Patient Class Code
20: SNF
23: IMR-title XIX Elig
24: Dual Medicare/Medicaid
26: Swing Bed
27: IMR-noneligible for title XIX
29: Full Medicare
40: Exceptional Therapy Care
45: Alien Emergency Medical (AEM) Program, Non-Medicaid Eligible
50: Behavioral support
60: Community Home Project

Revenue Code

Bill nursing facility claims using revenue code **0190** (Subacute Care General Classification) in form locator 42 on the UB-04 claim form.

Patient Status Codes

DSHS is now using CMS patient status codes instead of the previous turnaround document (TAD) discharge codes (see table below). Enter the appropriate Patient Status Code in form locator 22 on the UB-04 claim form.

TAD Discharge Code	CMS Patient Status Code
1: To hospital	**02:** To hospital **05**: Discharged/Transferred to a Designated Cancer Center or Children's Hospital
2: To another nursing facility	**03:** To skilled nursing facility
4: Deceased	**20:** Expired (also use when a patient is admitted and dies on the same day)
5: Private pay, hospice, home, or social leave	**01:** Home
	50: Hospice/home
	51: Hospice/medical facility
6: Still a patient	**30:** Still a patient
7: To state hospital	**70:** To another type of institution
9: To congregate care facility	**04:** To ICF (Intermediate Care Facility)

Billing

What Are the General Billing Requirements?

Providers must follow DSHS's *General Information Booklet* at http://hrsa.dshs.wa.gov. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill DSHS for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients; and
- Record keeping requirements.

Third-Party Liability

Information about third-party liability is available online at: http://hrsa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/Nursing Facilities.html

Click on the "Skilled Nursing Facilities Cost Avoidance" link under "Resource Links" on the right hand side of the page. This link connects to the "Coordination of Benefits" page, select "download a PDF on Cost Avoidance" under "Other useful information:".

How Do I Bill When a Client is Admitted and Dies on the *Same Day*?

If a client is newly admitted and dies on the ***same day***, use Patient Status 20 when billing this claim. This **does not include** when a client is admitted and discharged on the same day.

How Do I Bill for a Client Who Is Discharged in a Current Month?

When discharging a client from your facility, use the appropriate Patient Status Code and enter the total number of units not including the discharge day.

Will I Be Paid for the Date of Discharge?

No. DSHS does not pay nursing facilities for the date of discharge for Medicaid clients (keep this in mind when entering total number of units).

If Medicare has charged a coinsurance for the date of discharge, you may bill DSHS for coinsurance charges for QMB Only Medicare clients.

How Do I Bill for Social Leave?

DSHS pays for the first 18 days of Social Leave in a year. Report the client as *still a client* for these days. Do not discharge and readmit the client. After 18 days of Social Leave have been used, report discharge and readmit only if the client left the facility for at least a full 24-hour period.

How Do I Change a Previously Paid Claim?

If you need to make changes to claims for dates of service that DSHS has already paid (e.g., because of the change in patient participation, split months, discharge in error), you *must* submit an adjustment either electronically or use the Adjustment Request (525-109) form, DSHS 13-715 (refer to the Important Contacts section for information on ordering this form).

Note: DO NOT REBILL THE PAID CLAIMS. You may submit one adjustment per Internal Control Number (ICN) only.

Where On the Form Do I Enter Patient Participation? (Form Locator 39.-41.)

Enter the client Patient Participation amount into form locators 39-41 using value code 31, Do not enter it into form locator 57. These funds must be contributed toward the patient's cost of care, except when billing for patient classes Code 24 and 29. For a definition of "Patient Participation," please refer to the Definitions and Abbreviations Section in these billing instructions.

You may not collect participation from a DSHS client when billing for Class Code 29 and Class Code 24 Medicare days.

DSHS cannot reduce a Medicaid client's participation liability using unpaid Part C copayment or coinsurance charges if the Medicare payment exceeds the maximum reimbursement that is allowed under Medicaid.

DSHS does not calculate participation for QMB Only clients, and these clients are not required to contribute towards the cost of care while in the nursing facility.

Where on the Form Do I Enter the Spenddown Amount?
(Form Locator 39.-41.)

Enter the client spenddown amount into form locators 39-41 using value code 66. Do not enter it into form locator 57. For a definition of "spenddown" please refer to the Definitions and Abbreviations Section in these billing instructions.

How Do I Bill for Clients Who Are Eligible for Medicare and Medicaid or Clients Who Are QMB Only?

Bill Medicare first. If you bill Medicaid for a class 29 or 24 prior to the Medicare payment, you will automatically receive a $0.00 reimbursement from Medicaid. If money is owed to you on a class 24 claim after Medicare makes payment, you must submit an adjustment form with the appropriate Medicare backup.

- If Medicare pays the claim, the provider must bill DSHS within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, DSHS requires the provider to meet DSHS's initial 365-day requirement for initial claim.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice, and some home health care. Check the client's red, white, and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage. Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

When billing Medicare:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the Medical Identification card. Enter the Medical Assistance provider number.

- Accept assignment.

- If Medicare has allowed the service, send the UB-04 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to DSHS for processing.

- When Part A services are totally disallowed by Medicare but are covered by DSHS, bill DSHS on the UB-04 claim form and attach copies of Medicare's EOMB with the denial reasons.

Note:
- ✓ Medicare/Medical Assistance/QMB only billing claims must be received by DSHS within six (6) months of Medicare's EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Medicare Advantage Plans (Part C)

[Refer to Memo 09-02]

DSHS reimburses nursing facilities for Medicare Part C cost sharing expenses up to the maximum reimbursement limits established under WAC 388-502-0110 and WAC 388-517-0320.

- In order to receive payment from DSHS, it is necessary to follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing DSHS. If you bill Medicaid for a class 29 or 24 prior to Managed Medicare payment, you will automatically receive a $0.00 reimbursement from Medicaid.

Note: Some Medicare clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C). The Managed Medicare – Medicare Advantage Plan is the primary payer. *Providers are required to bill Medicare Advantage Plans instead of Fee-For-Service (FFS) Medicare.*

- After the Medicare Advantage plan processes the claim, if money is owed, an adjustment form must be submitted with the appropriate Managed Medicare – Medicare Advantage (Part C) EOB to DSHS. Bill DSHS on the same claim form you used to bill the Medicare Advantage plan. Make sure the services and billed amounts match what you billed to the Medicare Advantage plan. Attach the Medicare Advantage EOB.

- DSHS must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.

- If Medicare denies a service that requires prior authorization (PA), DSHS waives the PA requirement, but still requires some form of DSHS authorization based on medical necessity.

Billing DSHS for Managed Medicare – Medicare Advantage (Part C) Plans

In order to receive payment from DSHS, it is necessary to follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing DSHS.

If there is a capitated copayment due on a claim:

Capitated copayments do not require the biller to submit an explanation of benefits (EOB); with the claim. Indicate "Managed Medicare capitated copayment" on billing forms as follows:

- CMS-1500 Claim Form in field 19;
- UB-04 in form locator 80; or
- Electronic billing in the online comments.

If there is coinsurance, a deductible, or a noncapitated copayment due on a claim:

If no balance is due for services provided, the claim will be denied.

If a balance is due for services provided:

- Bill all services, paid or denied, to DSHS on one claim form, and attach an EOB.
- Indicate "Managed Medicare" on billing forms as follows:

  - ✓ CMS-1500 Claim Form in field 19;
  - ✓ UB-04 in form locator 80; or
  - ✓ Electronic billing in the on-line comments.

- DSHS will compare the allowed amount for DSHS and Managed Medicare – Medicare Advantage and select the lesser of the two.

- Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage.

Note: If the Medicare Advantage plan covers a service that DSHS requires PA for, DSHS will waive the PA requirement.

QMB-Medicare Only

For QMB-Medicare Only clients:

- If Medicare and DSHS cover the service, DSHS pays only the deductible and/or coinsurance and/or copayment up to Medicare or Medicaid's allowed amount, whichever is less. Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage.

- If only Medicare covers the service and DSHS does not, DSHS pays only the deductible and/or coinsurance up to Medicare's allowed amount.

- If Medicare does not cover the service, DSHS does not reimburse the service.

Completing the UB-04 Claim Form

Note: These instructions are specific to nursing facilities. *Form Locator numbers with an asterisks (*****) in front of them are required by DSHS to process a nursing facility claim.*

Bill only dates of service for which the client is eligible.

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

***1. Provider Name, Address & Telephone Number** - The provider name, address, and telephone number as filed with the DSHS Division of Healthcare Services.

4. Type of Bill – Enter:

a. 0211 for claims;
b. 0217 for adjustments; and
c. 0218 for voids.

6. Statement Covers Period - Enter the beginning and ending dates of service for the period covered by this bill.

***8.a. Patient ID Number** - The client's identification number if different from the subscriber/insured's ID.

***8.b. Patient Name** – The client's last name, first name, and middle initial as shown on the client's Medical Identification Card.

***9. Patient Address** - The client's address.

***10. Patient Birthdate** - The client's birthdate. (MMDDYYYY)

***11. Patient Sex** - The client's sex. (M or F)

12. Admission Date - The date of admission. (MMDDYYYY)

13. Admission Hour – The hour which the patient was admitted for care.

***14. Priority (Type) of Visit** – The priority (type) of admission. Enter:

a. 1 for Emergency;
b. 2 for Urgent;
c. 3 for Elective; and
d. 5 for Trauma

***15. Admission Source** – The source of admission. Enter:

a. 1 Physician Referral;
b. 2 Clinic Referral;
c. 3 HMO Referral;
d. 4 Transfer from a Hospital;
e. 5 Transfer from a Skilled Nursing Facility;
f. 7 Emergency Room; and
g. A Transfer from a Critical Access Hospital

16. Discharge Hour – The hour during which the patient was discharged from care.

***17. Discharge Status/Patient Status** - Enter a valid Patient Status code to represent the disposition of the patient's status. See page C.2.

31.-34. Occurrence Code and Date - The appropriate occurrence code and related date.

35. Occurrence Span - The appropriate occurrence code and related dates.

38. Responsible Party Name and Address –The name and address of the party responsible for the bill.

39.-41. Value Codes and Amounts –The following Value Codes are required to process your nursing facility claims:

Value Code 24 – Enter this code in the code field with the Patient Class immediately following in the amount field. See page C.1 for valid Patient Class codes. (e.g., 20.00=class code 20)

Value Code 31 – Enter this code in the code field with the Patient Participation amount for the entire month immediately following in the amount field.

Value Code 66 – Enter this code in the code field with the entire Patient Spenddown Amount immediately following in the amount field.

***42. Revenue Code** - Enter revenue code 0190.

***43. Revenue Descriptions (Procedure Descriptions)** – (Required for Paper Only) The description of the related revenue code. Abbreviations may be used.

***44. HCPCS/Rates** - Enter nursing facility daily rate.

45. Service Date – Same as form locator 6.

***46. Units of Service** - Enter the number of days. Do not include the date of discharge. See pages D.2 and D.3.

***47. Total Charges** – Equals the amount in form locator 44 multiplied by the amount in form locator 46.

48. Non-Covered Charges - Any charges not covered by DSHS.

***50. Payer Identification: A/B/C** - All health insurance benefits available.

50A: Enter Primary Payer.
50B: Enter the name of the Secondary Payer (e.g., Medicaid, Medicare, Aetna, etc.), if applicable.
50C: Enter the name of the Tertiary Payer, if applicable.

***51. Health Plan ID Number** - Enter the nursing facility provider number issued to you by DSHS. This is the 7-digit provider number beginning with a "4" that appears on your Remittance and Status Report.

***54. Prior Payments: A/B/C** - The amount due or received from all insurances. **Do not include participation amount here.**

54A: Any prior payments from payer listed in form locator 50A.
54B: Any prior payments from payer listed in form locator 50B.
54C: Any prior payments from payer listed in form locator 50C.

55. Estimated Amount Due: A/B/C –

55A: The estimated amount due from Primary payer minus any amounts listed in form locators 54 and 39-41.
55B: The estimated amount due from Secondary payer minus any amounts listed in form locators 54 and 39-41.
55C: The estimated amount due from Secondary payer minus any amounts listed in form locators 54 and 39-41.
***Note:** Medicaid will usually be the primary or the secondary payer.

***58. Insured's Name: A/B/C** – The insured's name if other insurance benefits are available and coverage is under another name.

60. Insured's Unique ID: A/B/C - Enter the unique number assigned by the health plan to the insured (following A/B/C for form locators 50-55). For the line represented by Medicaid, enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each DSHS client - exactly as shown on the Medical ID card. This information is obtained from the client's current monthly Medical ID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tiebreaker).

61. Insurance Group Name - If other insurance benefits are available, the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization Codes** - The assigned authorization number.

65. **Employer Name** - If other insurance benefits are available, the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

***67.** **Principal Diagnosis Code** - The ICD-9-CM diagnosis code describing the principal diagnosis.

67.a.-q. **Other Diagnosis Codes** – Any additional ICD-9-CM diagnosis codes indicating any other conditions.

***69.** **Admitting Diagnosis Code** – The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

74. **Principal Procedure** – The code that identified the principal procedure performed during the period covered by this bill.

76. **Attending- Physician Name and I.D. (NPI/QUAL/ID)** - The 7-digit provider identification number issued by DSHS. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

78.-79. **Other ID- Physician I.D. (NPI/QUAL/ID).** - The referring provider number issued by DSHS.

80. **Remarks** - Any information applicable to this stay that is not already indicated on the claim form such as extended stay approval.