Hospice Services Appendices

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Appendix K-1

Explanation of Information On Provider Information Sheet

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and the Department notified immediately via IMPACT.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is identified as Appendix K-1a.

Field	**Explanation**
Provider Key	This number uniquely identifies the provider and is used internally by the Department. It is directly linked to the reported NPI shown in Field 7.
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** code identifies the county in which the provider maintains its primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the hospice.
Enrollment Specifics	This area contains basic information reflecting the manner in which the provider is enrolled with the Department. **Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification.

Field	Explanation
Enrollment Specifics	**Organization Type** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: 01 = Sole Proprietary 02 = Partnership 03 = Corporation **Enrollment Status** is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the Department's Medical Programs. Cost report requirements are also indicated. The possible codes are: B = Active, Cost Report Not Required I = Inactive Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "Active" will appear in the **End** date field. **Exception Indicator** may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A = Intent to Terminate B = Expired License C = Citation D = Delinquent Child Support E = Provider Review F = Fraud Investigations G = Garnishment I = Indictment L = Student Loan Suspensions R = Intent to Terminate/Recovery T = Tax Levy X = Tax Suspensions If this item is blank, the provider has no exception. Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.

Field	Explanation
Medicare Number	This is the number that the Medicare processing agency uses to identify the hospice.
Categories of Service	This area identifies the types of service a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. Each entry is followed by the date that the provider was approved to render services for each category listed. **The possible codes for a Hospice are:** 060 = Home Care 061 = General Inpatient 062 = Continuous Care Nursing 063 = Respite Care
Payee Information	This area records the name and address of the entity authorized to receive payments on behalf of the hospice. The payee is assigned a single digit **Payee Code.**
	Payee ID Number is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.
NPI	The National Provider Identification Number contained in the Department's database.

Appendix K-1a
Reduced Facsimile of Provider Information Sheet

```
MEDICAID SYSTEM (MMIS)                          STATE OF ILLINOIS                          RUN DATE: 01/04/16
PROVIDER SUBSYSTEM                  DEPARTMENT OF HEATLHCARE AND FAMILY SERVICES           RUN TIME: 11:47:06
REPORT ID:  A2741KD1                        PROVIDER INFORMATION SHEET                   MAINT DATE: 01/04/16
SEQUENCE:   PROVIDER TYPE                                                                        PAGE:    84
          PROVIDER NAME

- -PROVIDER KEY- -        PROVIDER NAME AND ADDRESS
    000011111111
                         COMMUNITY HOSPICE
                         131 MAIN STREET
                         HOMETOWN  IL  60001
                         COUNTY  009-CENTRAL
                         TELEPHONE NUMBER (999)555-1234

                         RE-ENRL IND:  E    DATE: 09/05/11

PROVIDER TYPE:         039 - HOSPICE
ORGANIZATION TYPE:      03 - CORPORATION
ENROLLMENT STATUS        B - ACTIV NOCST     BEGIN 11/15/94 END ACTIVE
EXCEPTION INDICATOR        - NO EXCEPT       BEGIN          END
                                                        AGR: YES  BILL: NONE

CERTIFIC/LICENSE NUM - 002001428  ENDING -
CLIA #:
LAST TRANSACTION ADD              AS OF 04/21/97   MEDICARE #141569
FACILITY CTL/AFFIL:

  PROCEDURE                          BEGIN     CURRENT     PROCEDURE                          BEGIN     CURRENT
    CODE       PROCEDURE DESCRIPTION  DATE      RATE          CODE       PROCEDURE DESCRIPTION  DATE      RATE

  65100000     NO DESCRIPTION FOUND  10/01/07   0.00        65200000     NO DESCRIPTION FOUND  10/01/07   0.00
  65500000     NO DESCRIPTION FOUND  01/01/08   0.00        65600000     NO DESCRIPTION FOUND  01/01/08   0.00

                                              ELIG                                                ELIG        TERMINATION
 COS     ELIGIBILITY CATEGORY OF SERVICE      BEG DATE     COS     ELIGIBLITY CATEGORY OF SERVICE BEG DATE      REASON
 060     HOME CARE                            11/15/94     061     GENERAL INPATIENT              11/15/94
 062     CONTINUOUS CARE NURSING              11/15/94     063     RESPITE CARE                   11/15/94

 PAYEE
 CODE       PAYEE NAME              PAYEE STREET          PAYEE CITY        ST  ZIP     PAYEE ID NUMBER      EFF DATE
  1         COMMUNITY HOSPICE       131 MAIN STREET       HOMETOWN          IL  60001   363944424-60001-01   11/15/94
                                                                                        TIN#: 01

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
    xxxxxxxxxx
                                        **********  PLEASE NOTE:  *********

* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____      X_____
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Appendix K-2

UB-04 Requirements for HFS Adjudication

Instructions for completion of this form follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. For detailed form locator information, **all hospices should have a copy of the UB-04 Data Specifications Manual for reference.** To become a UB-04 Subscriber, refer to the National Uniform Billing Committee (NUBC) website. The UB-04 Data Specifications Manual contains a blank facsimile of the UB-04. Providers may also view a UB-04 facsimile on the Department's website. For billing purposes, providers must submit an original UB-04.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Completion	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
Conditionally Required	**2.**	**Pay-To Name and Address** – Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-to Address is required when the address for payment is different than that of the Billing Provider in FL 1.
Optional	**3a.**	**Patient Control Number**
Optional	**3b.**	**Medical Record Number**

Completion	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
Required	**4.**	**Type of Bill** – A 4-digit field is required. Do not drop the leading zero in this field.
Optional	**5.**	**Fed. Tax No.**
Required	**6.**	**Statement Covers Period**
Optional	**10.**	**Patient Birth Date** – If the birth date is entered, the Department will, where possible, correct claims suspended due to participant name and number errors. If the birth date is not entered, the Department will not attempt corrections.
Required	**12.**	**Admission Date**
Required	**17.**	**Patient Discharge Status**
Conditionally Required *New Effective August 1, 2019*	**31-34.**	**Occurrence Code and Date** – For claims containing charges for the Service Intensity Add-on available for the last seven days of the patient's life, enter Occurrence Code 55 and the patient's date of death. If the SIA days span two calendar months, the occurrence code and date of death must be entered on the claim preceding the final claim and also entered on the claim for the month in which death occurred.
Conditionally Required	**35-36.**	**Occurrence Span Code/From/Through** – Indicate the non-covered date span.

Completion	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
Required *Revised Effective November 1, 2019*	**39-41.**	**Value Codes** – Value Code 80 is required for all hospice claims (the number of days covered by the primary payer). The other value codes below are conditionally required based upon the particular claim: Value Code 81 – The number of days of care not covered by the primary payer. Value Code G8 – Providers must use Value Code G8 in the code field with the appropriate CBSA in the amount field on their claims to identify the location of the inpatient facility where inpatient respite (Revenue Code 0655) or general inpatient (Revenue Code 0656) care services were provided. The CBSA code is to be reported right justified to the left of the dollar/cents delimiter. Rural CBSA code 14 must be completed as 99914. Value Code 61 – Providers must use Value Code 61 in the code field with the appropriate CBSA in the amount field on their claims to identify the location where routine home care (Revenue Code 0651) or continuous home care (Revenue Code 0652) services were provided. The CBSA code is to be reported right justified to the left of the dollar/cents delimiter. Rural CBSA code 14 must be completed as 99914. Value Code 66 – Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The 2432, Split Billing Transmittal, must accompany the claim.
Required	**42.**	**Revenue Code** – Enter the appropriate hospice Revenue Code(s) for the service provided. 055X – Service Intensity Add-on/Registered Nurse Service 056X – Service Intensity Add-on/Social Work Services 0651 – Routine Home Care 0652 – Continuous Home Care 0655 – Respite Care 0656 – General Inpatient Care 0657 – Physician Services 0658 – Nursing Home Room and Board The 23rd revenue line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

Completion	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
Required	**43.**	**Revenue Description**
Required	**44.**	**HCPCS/Accommodation Rates** – For Revenue Codes 0651, 0652, 0655, 0656, and 0658, report the rate assigned to the revenue code. For Revenue Code 055X, report HCPCS code G0299. For Revenue Code 056X, report HCPCS code G0155. For Revenue Code 0657, report the HCPCS/CPT associated with the service.
Required *Revised Effective August 1, 2019*	**45.**	**Service Date** A service line date is required on **all** hospice services. Prior to August 1, 2019, a service line date was already required for Revenue Codes 0652 – Continuous Home Care, 055X – Registered Nurse Service (SIA Add-on), and 056X – Social Work Services (SIA Add-on) to identify the service units billed each day. For Revenue Codes 0651 – Routine Home Care, 0655 – Inpatient Respite Care, 0656 – General Inpatient Care, 0657 – Physician Services and 0658 – Nursing Home Room and Board: Providers may combine the total number of days for one revenue code on one line showing the beginning service date in FL 45 and the total number of days in FL 46, **as long as the service dates are consecutive.** If the service dates are not consecutive, providers need to split the dates for that revenue code on separate service lines rather than combining the days on one line. This is especially important for the calculation of the RHC high/low payment rate.
Required	**46.**	**Service Units** • Revenue Code 055X is reported in ¼ hour units • Revenue Code 056X is reported in ¼ hour units • Revenue Code 0651 is reported in calendar days • Revenue Code 0652 is reported in ¼ hour units • Revenue Code 0655 is reported in calendar days • Revenue Code 0656 is reported in calendar days • Revenue Code 0657 is reported as the number of physician visits associated with the HCPCS code billed • Revenue Code 0658 is reported in calendar days
Required	**47.**	**Total Charges** (By Revenue Code category) For revenue code 0001, see FL 42 above.
Conditionally Required	**48.**	**Non-Covered Charges** – Reflects any non-covered charges pertaining to the related revenue code.

Completion	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
Required	**50.**	**Payer** – Illinois Medicaid or 98916 must be shown as the payer of last resort
Conditionally Required	**51.**	**Health Plan Identification Number** **Three-Digit TPL Code [space] Two-Digit Status Code** (Required if there is a third party source) **TPL Code** – If the patient's medical card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in the TPL Code Directory on the Department's website. **Status Code** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **05 – Patient Not Covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified is not in force. **06 – Services Not Covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **08 – Estimated Payment:** TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.

Completion	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
Conditionally Required	**54A,B.**	**Prior Payments –** TPL payments are identified on lines A and B to correspond to any insurance source in FL 51 lines A and B.
Required	**56.**	**National Provider Identifier** – **Billing Provider** The NPI is the unique identification number assigned to the provider submitting the bill.
Optional	**57.**	**Other (Billing) Provider Identifier** – Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. The HFS legacy number will not be used for adjudication.
Required	**58.**	**Insured's Name** – Enter the patient's name exactly as it appears on HFS records.
Required	**60.**	**Insured's Unique Identifier (Recipient Identification Number)** – Enter the nine-digit recipient number assigned to the individual. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Conditionally Required	**64.**	**Document Control Number** – At the time the Department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
Required	**67.**	**Principal Diagnosis Code and Present on Admission Indicator** – Enter the specific ICD-10 code without the decimal. A POA indicator is **not** required for hospice claims.
Conditionally Required	**67A-Q.**	**Other Diagnosis Codes** – Enter the specific ICD-10 code without the decimal. A POA indicator is **not** required for hospice claims.
Required	**69.**	**Admitting Diagnosis Code** – Enter the specific ICD-10 code without the decimal.

Completion	Form Locator	Form Locator Explanation and Instructions for Hospice Claims
Conditionally Required	**72A-C.**	**External Cause of Injury (ECI) Code** – The ICD-10 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
Required	**76.**	**Attending Provider Name and Identifiers** – The Department will adjudicate claims based on the NPI.
Required	**81.**	**Code-Code Field** – HFS Requirement (Needed for Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Chapter 300 Handbook for Electronic Processing, available on the Department's website. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

***Additional notes**

Form Locator 80 Remarks – HFS utilizes this field to assign each claim's unique Document Control Number. Providers do not utilize this field.

Mailing Instructions

The provider is to submit an original UB-04 form to the Department. The pin-feed guide strip should be detached from the sides of continuous feed forms. A copy of the claim is to be retained by the provider.

UB-04 paper claims should be sent to the applicable post office box as follows:

UB-04 Claims Without Attachments:

Illinois Department of Healthcare and Family Services
UB-04 Inpatient/Outpatient Invoices
P.O. Box 19132
Springfield, Illinois 62794-9132

UB-04 Claims With Attachments:

Illinois Department of Healthcare and Family Services
UB-04 Inpatient/Outpatient Invoices
P.O. Box 19133
Springfield, Illinois 62794-9133

UB-04 Claims Requiring Special Handling by the Billing Consultants:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
P.O. Box 19128
Springfield, Illinois 62794-9128

Adjustments (Form HFS 2249):

Illinois Department of Healthcare and Family Services
MMIS Adjustments
P.O. Box 19101
Springfield, Illinois 62794-9101

Forms Requisition:

The Department does not supply the UB billing form. The HFS 2249 Adjustment form is available in an electronic PDF-fillable format on the Department's website.

The Department does supply a pre-addressed mailing envelope, the HFS 1416 envelope, which providers may use to submit their adjustment forms. These envelopes may be ordered from the Forms Request page of the Department's website.

Appendix K-3

Billing Scenarios for the UB-04 Claim Format

This appendix contains examples of various types of hospice services that may be submitted to the Department. Form locators affected and instructions for completion are identified with each scenario. Hospices still need to reference Appendix K-2, Required Fields.

In all situations, if a hospice patient has Medicare Part A coverage, then all hospice services should be billed to Medicare. The only service that the Department would cover in this situation is nursing home room and board charges, if the patient resides in a long-term care facility.

Billing Scenario 1

The patient elected hospice care on October 10, 20XX, and was discharged deceased on October 25, 20XX. This claim includes 16 days of Routine Home Care, 16 days of Nursing Home Room and Board Charges, and 1 Physician Visit. The patient has no Medicare coverage.

Form Locator 4 – Type of Bill. The first digit in this form locator must be a "0". The second digit must be an "8". The third digit may either be a "1" or "2", to identify if the hospice is non-hospital based or hospital-based. The fourth digit must be a "1", to identify this as an admission through discharge claim.

Form Locator 17 – Status. Enter an appropriate code to identify the patient died in the facility.

Form Locator 39 – Value Codes. Enter Value Code 61 and the appropriate Core-Based Statistical Area (CBSA) code to identify the location where the Routine Home Care service is furnished. The CBSA should be right-justified to the left of the dollar/cents delimiter.

Form Locator 42 – Revenue Code. Identify revenue codes 0651 (Routine Home Care), 16 units; 0658 (Nursing Home Room and Board Charges), 16 units; and 0657 (Physician Services).

Form Locator 44 – HCPCS/Rates. For revenue codes 0651 and 0658, identify the daily rates. For Revenue Code 0657, identify the CPT/HCPCS code applicable to the physician service.

Billing Scenario 2

The patient elected hospice care November 27, 20XX and is still a patient. This claim is for service dates December 1, 20XX through December 31, 20XX. The patient had 25 days of Routine Home Care, 25 days of Nursing Home Room and Board, and six days of General Inpatient Care. The patient has no Medicare coverage.

Form Locator 4 – Type of Bill. The first digit in this form locator must be a “0”. The second digit must be an “8”. The third digit may either be a “1” or “2”, to identify if the hospice is non-hospital based or hospital-based. The fourth digit must be a “3”, to identify this as an interim continuing claim.

Form Locator 17 – Status. Enter a “30” to identify that the patient is continuing care.

Form Locator 39 – Value Codes. Enter Value Code 61 and the appropriate Core-Based Statistical Area (CBSA) code to identify the location where the Routine Home Care service is furnished. Enter Value Code G8 to identify the location of the inpatient facility for the General Inpatient Care. The CBSA associated with each Value Code should be right-justified to the left of the dollar/cents delimiter.

Form Locator 42 – Revenue Code. Identify revenue codes 0651 (Routine Home Care), 25 units; 0656 (General Inpatient Care), 6 units; and 0658 (Nursing Home Room and Board Charges), 25 units.

Form Locator 44 – HCPCS/Rates. Identify the daily rates for all three revenue codes. The long term care facility where the patient resides supplies the hospice with the current daily rate.

Billing Scenario 3

The patient elected hospice care on March 18, 20XX, and was discharged deceased on March 30, 20XX. The patient had 11 days of Routine Home Care (March 18 through March 28), 44 quarter-hour units of Continuous Home Care on March 29th, and 36 quarter-hour units of Continuous Home Care on March 30th. The patient has no Medicare coverage.

Form Locator 4 – Type of Bill. The first digit in this form locator must be a "0". The second digit must be an "8". The third digit may either be a "1" or "2", to identify if the hospice is non-hospital based or hospital-based. The fourth digit must be a "1", to identify this as an admission through discharge claim.

Form Locator 17 – Status. Enter an appropriate code to identify the patient died.

Form Locator 39 – Value Codes. Enter Value Code 61 and the appropriate Core-Based Statistical Area (CBSA) code to identify the location where the Routine Home Care and Continuous Home Care services were furnished. The CBSA should be right-justified to the left of the dollar/cents delimiter.

Form Locator 42 – Revenue Code. Identify revenue codes 0651 (Routine Home Care) and 0652 (Continuous Home Care). Since CHC was provided on two separate dates, revenue code 0652 must be identified for each day on separately dated line items.

Form Locator 44 – HCPCS/Rates. Identify the daily rate for revenue code 0651. Identify the quarter-hour rate for revenue Code 0652.

Form Locator 45 – Service Date. For each revenue line 0652, add the corresponding service date.

Form Locator 46 – Service Units. Identify the number of days of care for revenue code 0651. Identify the number of quarter-hour units for continuous home care for each service date.

Billing Scenario 4

The patient elected hospice care on June 24, 20XX. This claim is for service dates August 1, 20XX through August 31, 20XX. The patient received 31 days of Routine Home Care and 31 days of Nursing Home Room and Board. This patient has Medicare Part A coverage.

Form Locator 4 – Type of Bill. The first digit in this form locator must be a "0". The second digit must be an "8". The third digit may either be a "1" or "2", to identify if the hospice is non-hospital based or hospital-based. The fourth digit must be a "3", to identify this as an interim continuing claim.

Form Locator 17 – Status. Enter a "30" to identify that the patient is continuing care.

Form Locator 42 – Revenue Code. Only identify revenue code 0658 (Nursing Home Room and Board Charges). Since the patient has Medicare Part A coverage, the Routine Home Care charges must be billed to Medicare. The only charges billable to Illinois Medicaid are the Nursing Home Room and Board Charges.

Form Locator 44 – HCPCS/Rates. Identify the daily rate for the Nursing Home Room and Board Charges. The long term care facility where the patient resides supplies the hospice with the current daily rate.

Billing Scenario 5

The patient elected hospice care on April 18, 20XX and is still a patient. The dates of service are for May, 20XX. She receives Routine Home Care only. The patient has Blue/Cross/Blue Shield as her primary insurance, and also has a Spenddown. The Spenddown was met on May 3rd. She has no Medicare coverage.

The 2432, Split Billing Transmittal, must accompany any claim that encompasses the Split Bill Day (the day Spenddown was met). The 2432 must be attached to the claim for processing, even if the patient liability amount shown is zero. The patient's DHS local office (Family Community Resource Center, or FCRC) is responsible for calculating the Spenddown status.

Form Locator 4 – Type of Bill. The first digit in this form locator must be a "0". The second digit must be an "8". The third digit may either be a "1" or "2", to identify if the hospice is non-hospital based or hospital-based. The fourth digit must be a "3", to identify this as an interim continuing claim.

Form Locator 6 –Statement Covers Period. The From Date is "0503XX" and the Through Date is "0531XX".

Form Locator 17 – Status. Enter a "30" to identify that the patient is continuing care.

Form Locator 39 – Value Codes. Enter Value Code 80 with the number of covered days. In this situation, the patient was not eligible until May 3rd. This patient has 29 covered days. Enter Value Code 61 and the appropriate Core-Based Statistical Area (CBSA) code to identify the location where the Routine Home Care service is furnished. The CBSA should be right-justified to the left of the dollar/cents delimiter. Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability.

Form Locator 42 – Revenue Code. Identify revenue codes 0651 (Routine Home Care), 29 units.

Form Locator 44 – HCPCS/Rates. Identify the daily rate for revenue code 0651.

Form Locator 51 – Health Plan Identification Number. To identify the third party source, enter the three-digit TPL code, then a space, then the two-digit status code. In this field, **do not** enter any TPL information across from the Illinois Medicaid payer line.

Billing Scenario 6

The patient elected hospice care on March 15, 20XX. He is a nursing home resident. This claim is for service dates for the month of May, 20XX. The patient transferred from his original facility to another nursing home on May 20th. This patient has Medicare Part A coverage.

For the month of May, two claims for nursing home room and board charges will have to be submitted, as the rates for the two facilities are different.

First Claim:

Form Locator 4 – Type of Bill. The first digit in this form locator must be a "0". The second digit must be an "8". The third digit may either be a "1" or "2", to identify if the hospice is non-hospital based or hospital-based. The fourth digit must be a "3", to identify this as an interim continuing claim.

Form Locator 17 – Status. Enter a "30" to identify that the patient is continuing care.

Form Locator 39 – Value Codes. Enter Value Code 80 with the number of covered days. For this claim, the date of the transfer is not counted as a covered day. This claim has 19 covered days.

Form Locator 42 – Revenue Code. Only identify revenue code 0658 (Nursing Home Room and Board Charges). Since the patient has Medicare Part A coverage, the Routine Home Care charges must be billed to Medicare. The only charges billable to Illinois Medicaid are the Nursing Home Room and Board Charges.

Form Locator 44 – HCPCS/Rates. Identify the daily rate for the Nursing Home Room and Board Charges. The long term care facility where the patient resides supplies the hospice with the current daily rate.

Second Claim:

Form Locator 4 – Type of Bill. The first digit in this form locator must be a "0". The second digit must be an "8". The third digit may either be a "1" or "2", to identify if the hospice is non-hospital based or hospital-based. The fourth digit must be a "3", to identify this as an interim continuing claim.

Form Locator 17 – Status. Enter a "30" to identify that the patient is continuing care.

Form Locator 39 – Value Codes. Enter Value Code 80 with the number of covered days. For this claim, covered days begin with the date of the transfer to the new facility (May 20th) through the end of the month. This claim has 12 covered days.

Form Locator 42 – Revenue Code. Only identify revenue code 0658 (Nursing Home Room and Board Charges). Since the patient has Medicare Part A coverage, the Routine Home Care charges must be billed to Medicare. The only charges billable to Illinois Medicaid are the Nursing Home Room and Board Charges.

Form Locator 44 – HCPCS/Rates. Identify the daily rate for the Nursing Home Room and Board Charges. The facility to which the patient transferred supplies the hospice with the current daily rate.

Billing Scenario 7

The patient elected hospice care on March 10, 20XX, and was discharged deceased on May 30, 20XX. The patient had a total of 82 days of Routine Home Care (March 10 through May 8 will systematically be paid at the higher Routine Home Care rate; May 9 through May 30 will be paid at the lower rate).

This claim is for service dates May 1 through May 30th. The patient had 30 days of Routine Home Care. The hospice also billed for the service intensity add-on payment for the last four days of life as follows: On May 27, three hours were provided by a registered nurse and one hour by a social worker; on May 28, four hours were provided by a registered nurse; on May 29, three hours were provided by a registered nurse, and on May 30, three hours were provided by a registered nurse and ½ hour by a social worker. The patient has no Medicare coverage.

Form Locator 4 – Type of Bill. The first digit in this form locator must be a "0". The second digit must be an "8". The third digit may either be a "1" or "2", to identify if the hospice is non-hospital based or hospital-based. The fourth digit must be a "4", to identify this as the last claim in a series of bills.

Form Locator 17 – Status. Enter an appropriate code to identify the patient died.

Form Locator 39 – Value Codes. Enter Value Code 61 and the appropriate Core-Based Statistical Area (CBSA) code to identify the location where the Routine Home Care was furnished. The CBSA should be right-justified to the left of the dollar/cents delimiter.

Form Locator 39 – Value Codes. Enter Value Code 80 with the number of covered days. For this claim, the date of death is counted as a covered day. This claim has 30 covered days.

Form Locator 42 – Revenue Code. Identify revenue code 0651 (Routine Home Care), 055X (Skilled Nursing), and 056X (Home Health, Medical Social Services). Since the service intensity add-on services (055X and 056X) were provided on four separate dates, revenue codes 055X and 056X must be identified for each day given on separately dated line items. As these services can only be reimbursed in conjunction with Routine Home Care, Revenue code 0651 must also be identified on separately dated line items for those same four days billed.

Form Locator 44 – HCPCS/Rates. Enter HCPCS code G0299 for the nursing service and G0155 for the social worker services.

Form Locator 45 – Service Date. For all revenue codes on this claim (0651, 055X, 056X) associated with the dates for service intensity add-on billing, identify the corresponding service date.

Form Locator 46 – Service Units. Identify the number of days of care for revenue code 0651 for each service date. Identify the number of quarter-hour units for revenue code 055X and 056X for each service date.

Appendix K-4

Internet Quick Reference Guide

The Department's handbooks are designed for use via the Web and contain hyperlinks to the pertinent information.

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Centers for Medicare and Medicaid Services (CMS)
Child Support Enforcement
Claims Processing System Issues
Dental Program
FamilyCare
Family Community Resource Centers
Health Benefits for Workers with Disabilities
Health Information Exchange
Home and Community Based Waiver Services
Illinois Health Connect
Illinois Veterans Care
Illinois Warrior Assistance Program
Maternal and Child Health Promotion
Medical Electronic Data Interchange (MEDI)
State Chronic Renal Disease Program
Medical Forms Requests
Medical Programs Forms
National Uniform Billing Committee (NUBC)
Non-Institutional Provider Resources
Pharmacy Information
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
State Chronic Renal Disease Program