THE STATE OF TENNESSEE

Appendix B – HCBS User Guide

BUREAU OF TENNCARE

Long Term Care - User Manual

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Long Term Care User Manual – Appendix B

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Document Version #	Revision Date	Revision Page Numbers	Revision Completed By
Version 1.0	10/29/2007	All	Kim Carroll
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Overview

The Home and Community Based Services (HCBS) Waiver is an option created by section 1915(c) of the Social Security Act that allows state Medicaid programs flexibility in developing innovative programs using federal funds. The purpose of the HCBS waiver is to provide community based services as an alternative to institutional care settings such as hospitals, ICF/MR and nursing homes. Services provided in the waiver are typically not offered in the Medicaid State Plan. HCBS Waiver program services are tailored to meet the needs of targeted populations such as the elderly, persons with physical disabilities, developmental disabilities, mental retardation or mental illness. Tennessee currently has one HCBS Waiver program for the elderly and disabled and two Waiver programs for persons with mental retardation.

Getting Started – Internet

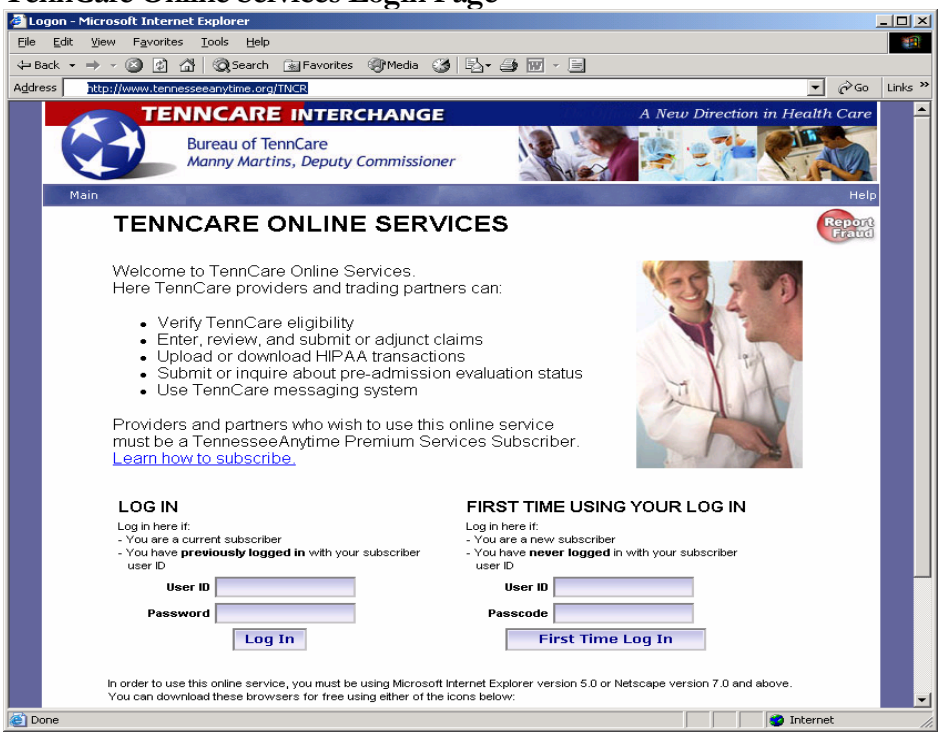
Before you can access the system, you must receive a letter from **NIC,** which provides a user name and login for first time users. Once you have received your letter, you can use the following URL to gain access to the system:

Before you can access the system, you must obtain a user ID and temporary password from TennCare's systems administrator. If you do not already have a **Tenneesee.Gov** Provider ID and password, the Internet address below will provide instructions on how to obtain and submit an application:

http://www.tennesseeanytime.org/tncr

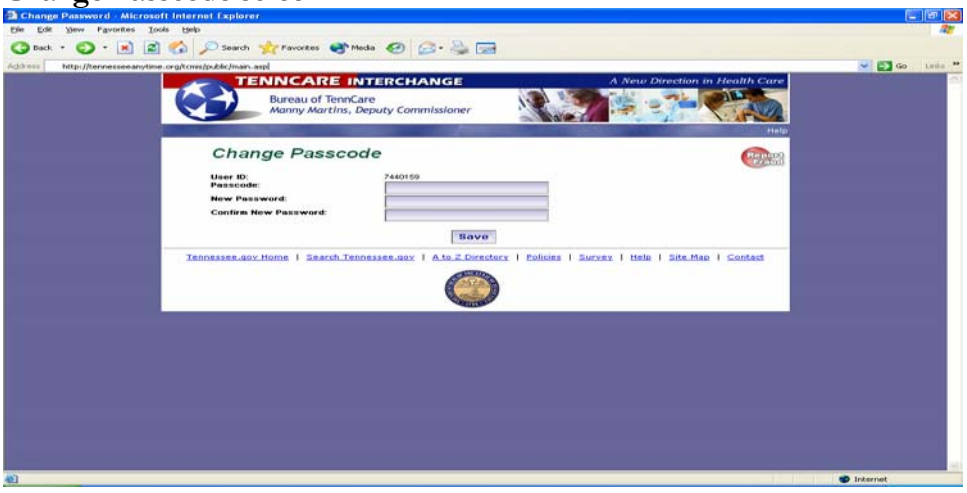
Once you have received your user ID and temporary password you can use the above Internet address to gain access to the system.

TennCare Online Services Login Page



1) If you're a first time user, you will type your user name and passcode in the "First Time Users" section and click **First Time Login**

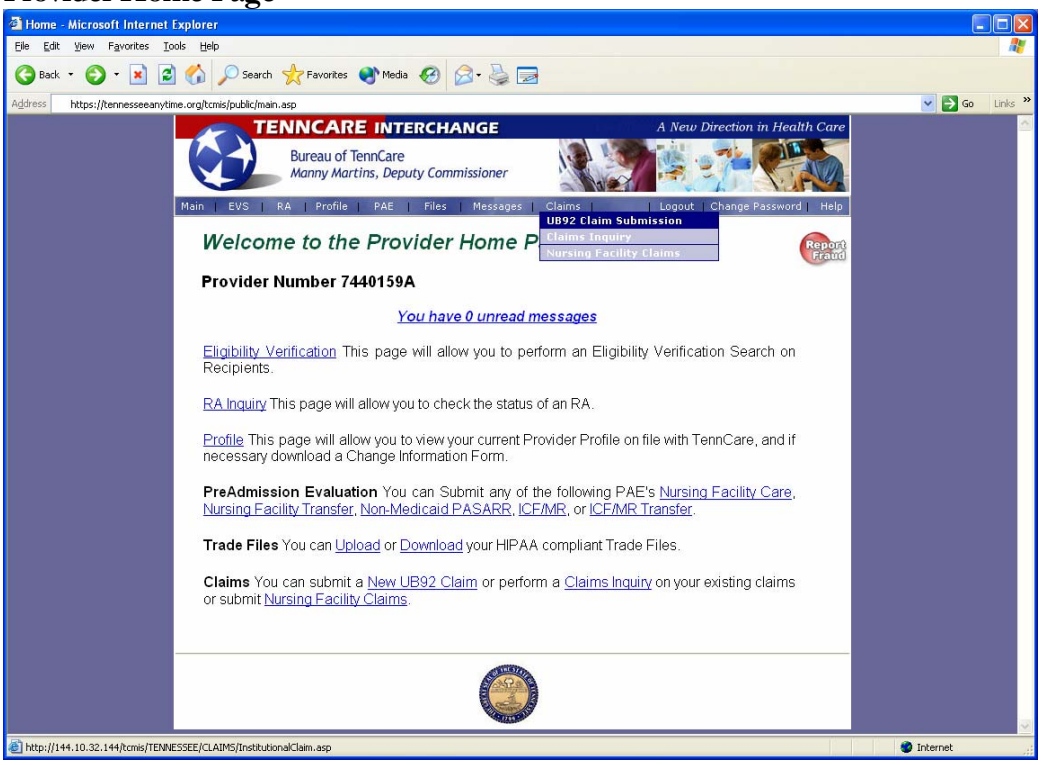
Change Passcode screen



1) Type your assigned passcode in the "Password" field
2) In the new password field, key in the new password. The password must be between 6-8 characters, at least two characters must be numeric. The confirmed password has to match the new password.

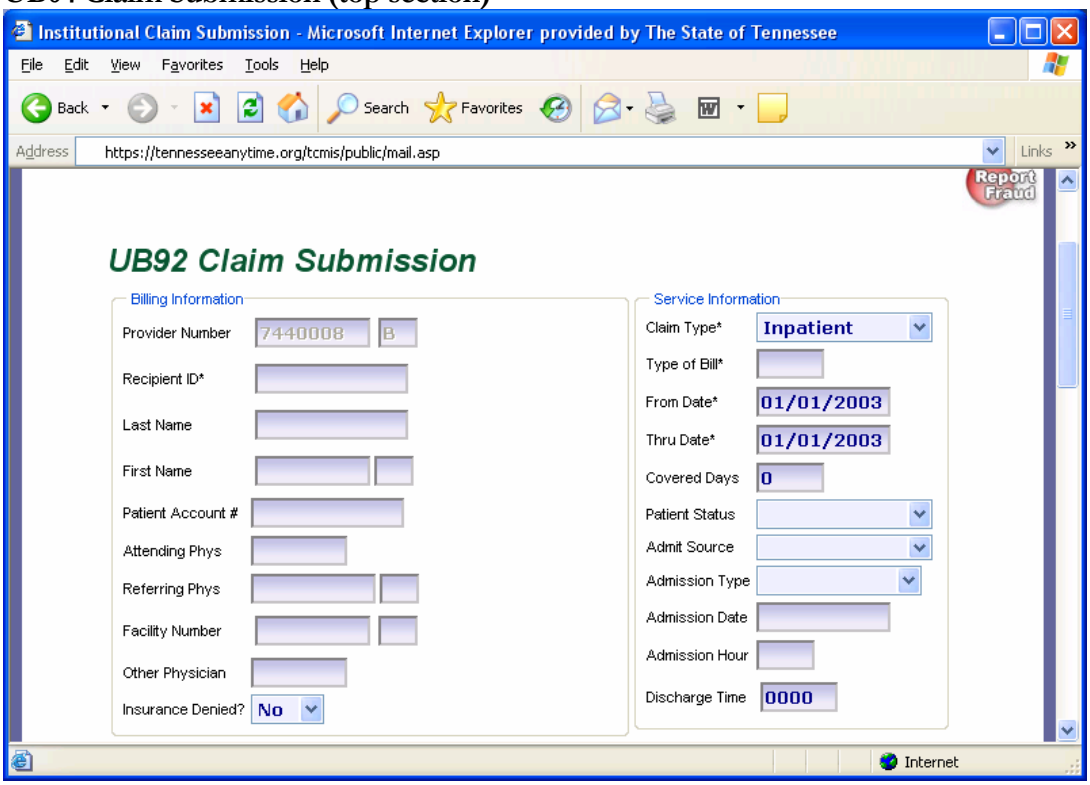
Instructions for Completing UB04 Form

Provider Home Page



1) Select UB04 Claim submission from the top menu or click on the "New UB04 Claim" link listed at the bottom of the Provider home page.

UB04 Claim Submission (top section)



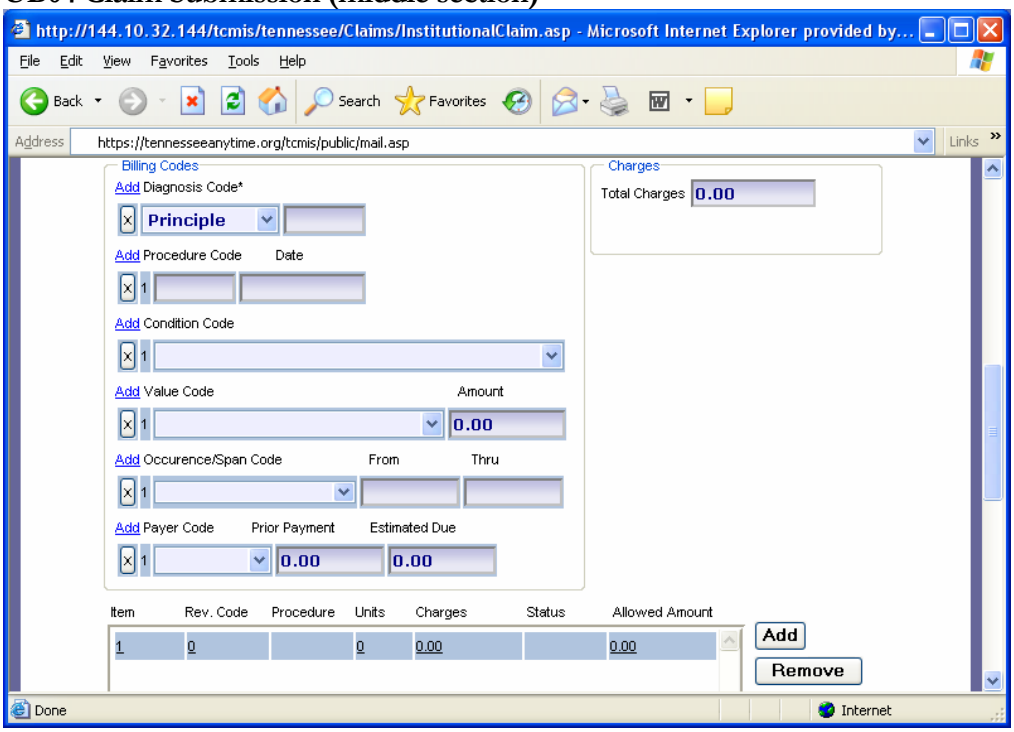
The UB04 consist of three sections (top, middle and bottom)
The following fields will need to be completed under the billing information section located at the upper left side on the claim form:

1) Provider number is populated based on sign-in (required)
2) Enter recipient ID#, and press tab key. Upon pressing the tab key the recipient's first and last name will populate. (required)
3) Enter the patient account # (required)
4) Attending physician ID (required on UB04). The number must be the practitioner's NPI number.
5) Referring physician ID (optional – but if utilized, must be the NPI)

The following fields will need to be completed under the service information section located on the upper right side of the claim form:

6) Claim type (required) - from the drop down box select HCBS claim
7) Type of bill, a three digit code indicates the specific type of bill (required)
   891----Admit
   892----Initial or first time billing
   893----Intermediate ongoing/continuing
   894----Intermediate final billing (discharge or death)
8) Enter the from and thru date (required) - this is the statement covered period
9) Patient Status (required) - select the status from the drop down box
10) Admission date (required) - cannot be later than "from date"

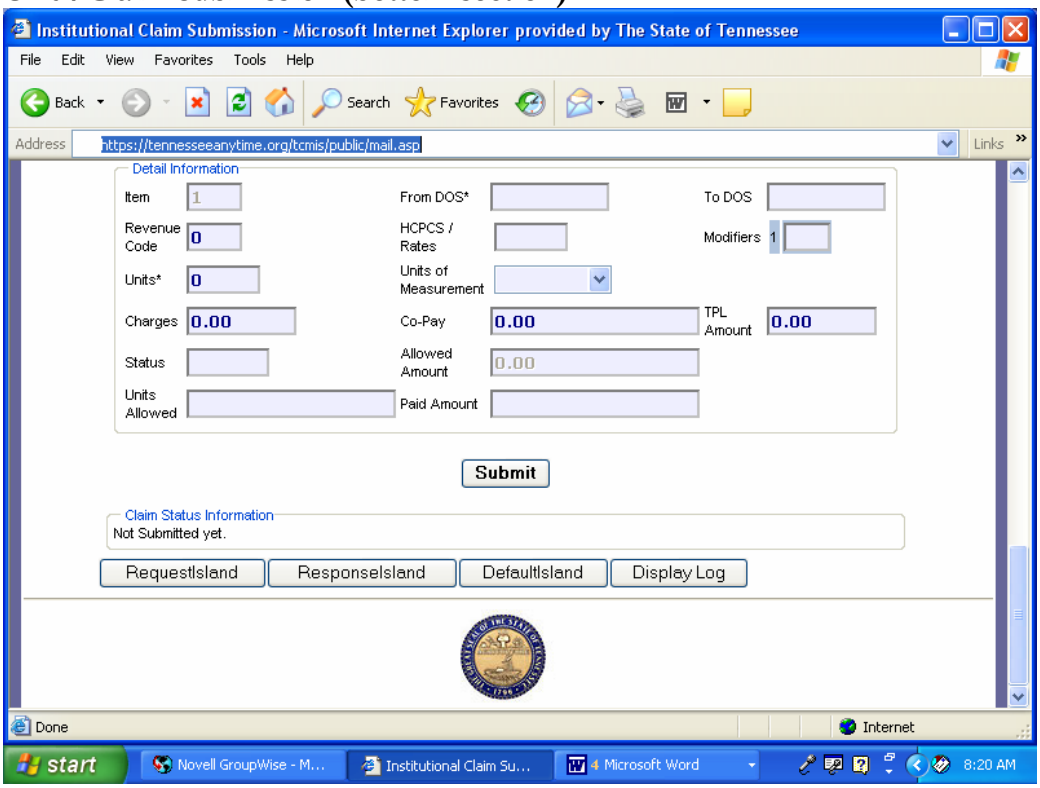
UB04 Claim Submission (middle section)



The following fields will need to be completed under the billing code section located on the middle left side of the claim form:

1) Enter diagnosis code in the shaded box (required)
2) Enter the Occurrence Code (required for physician recertification date)

UB04 Claim Submission (bottom section)



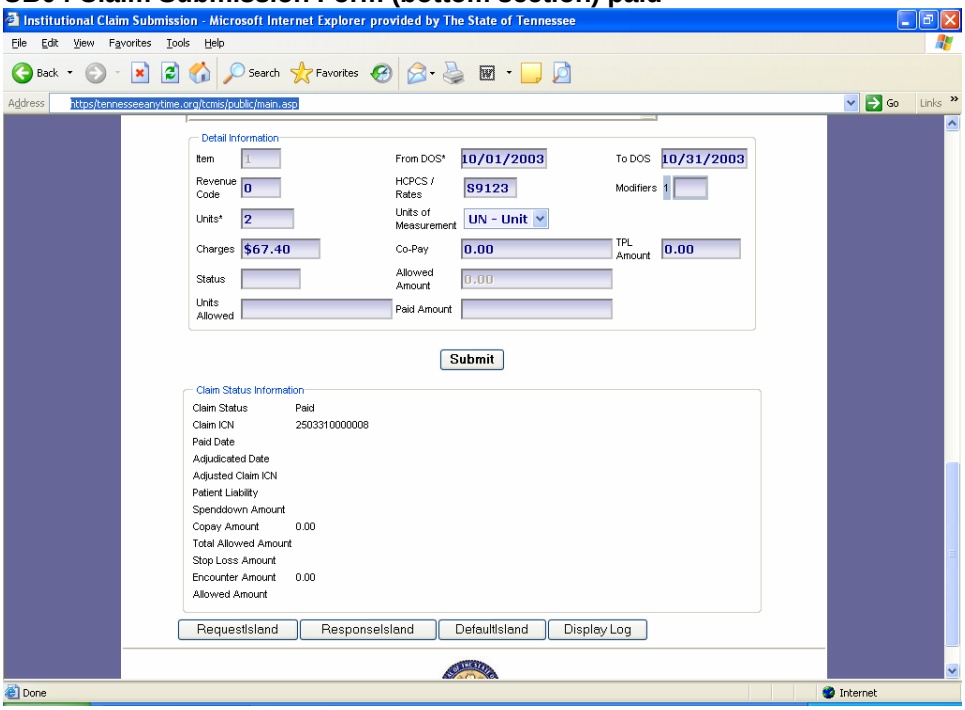
The following fields will need to be completed under the detail information section:

1) Enter the unit(s) of service provided (required)
2) Enter the HCPCS (required)
3) Enter charges (Should automatically populate)
4) Enter the from and thru dates of service (DOS) (required)
5) Enter the unit of measure, from the drop down box select "Day" or "Unit" (required)
6) Once all of the required fields are entered, click on submit

Initial Claims Status

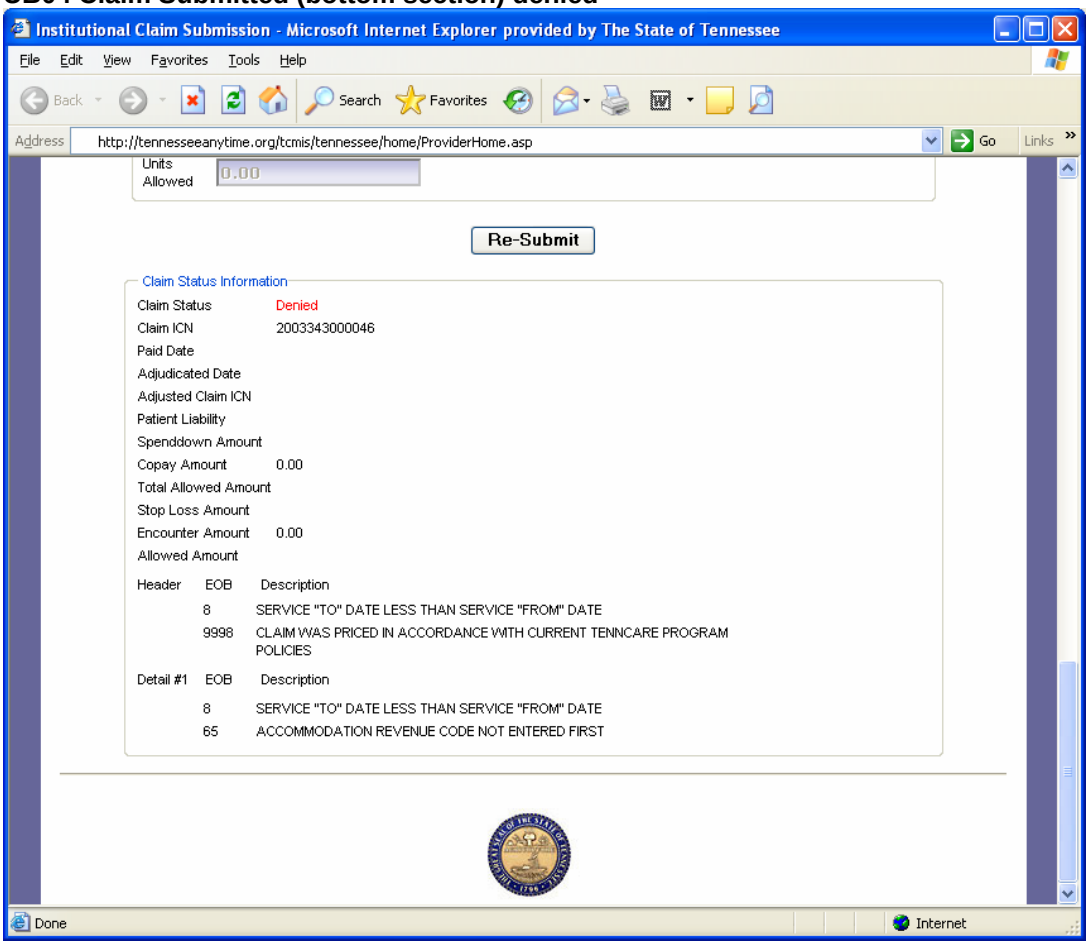
Once the claim has been submitted, the Claim Status Information section will list the current status of the claim as being paid, denied or suspended. The assigned ICN number will also appear.

UB04 Claim Submission Form (bottom section) paid



The window above indicates a **paid** status

UB04 Claim Submitted (bottom section) denied



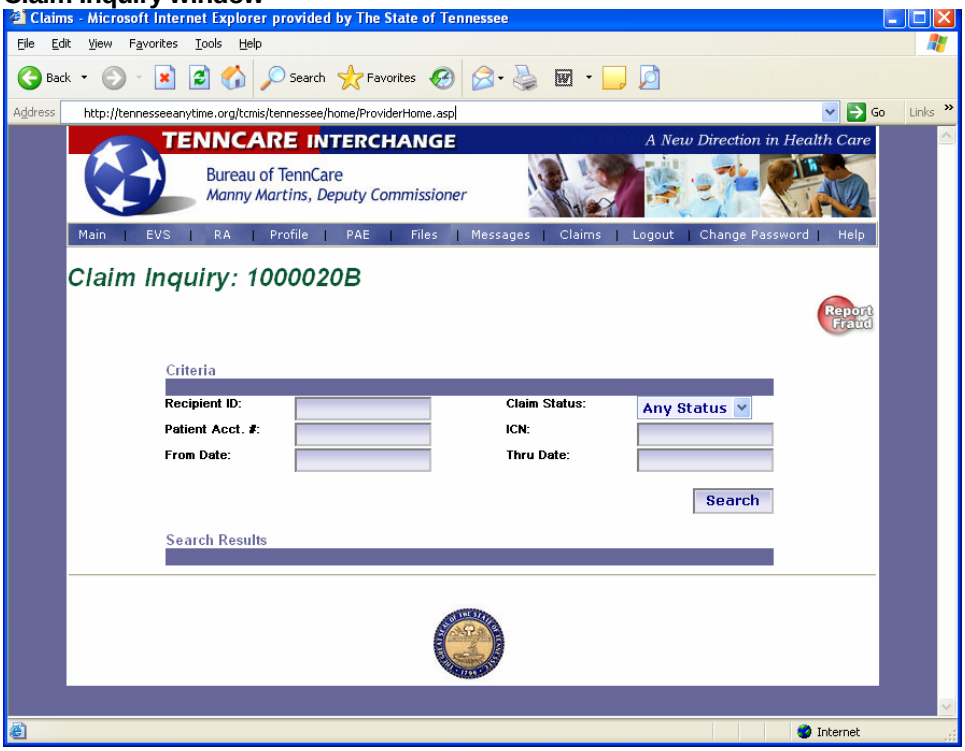
The window above indicates a **denied** status

Note: When a claim is denied, the reason(s) for the denial should be reviewed, corrected and then the claim should be resubmitted.

Claim Inquiry

This feature allows the user to search on previously submitted claims within the system. From the Provider Home page, click the "Claim Inquiry" link from the top menu.

Claim Inquiry window



A user can perform a claim inquiry by selecting any of the options listed below. Utilize as many options as possible to refine your search.

1) Enter recipient ID #
2) Claim status from drop down box (optional)
3) Enter ICN #, if available
4) Enter from and thru date
5) Click on the search button

Paper Claims Submissions

The table below outlines the required and operational fields that are used when submitting a paper claims. All HCBS paper claims will utilize the **387I** (UB04) form.

To obtain additional UB04 billing instructions, visit the CMS website:

http://www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf

See Attachment A for a copy of a UB04 paper claim.

UB04 REFERENCE Table

NUMBER	LOCATOR	REMARKS
1 **REQUIRED**	Provider Name, Address, and Telephone Number	Provider name must appear the same as on the enrollment form.
2 **SITUATIONAL**	Provider Pay to Address	Use only if the pay to address is different from the location address
3a **OPTIONAL**	Patient Control Number	Will be carried in the system and reported on the Remittance Advice. The number may be the medical record account number.
3b **OPTIONAL**	Medical Record Number	This is the Medical Record number of the patient.
4 **REQUIRED**	Type of Bill	A 3-digit code indicates the specific type of bill. 891—Admit through discharge 892—Initial or First time Billing 893—Intermediate ongoing/continuing 894—Intermediate final billing (discharge or death)
5 **REQUIRED**	Federal Tax ID #	This is the Federal Tax ID number of the billing provider.
6 **REQUIRED**	Statement covers Period	This billing period must include only that period for which the patient is an eligible recipient. Cannot be earlier than the Admission Date in Form Locator 12.
7	Blank	New field - Blank
8a **REQUIRED (IF APPLICABLE)**	Patient ID Number	This field is used if the subscriber/recipient ID is different as reported in Form Locator 60.
8b **REQUIRED**	Patient Name	Report name by using last, first and middle initial.
9a-e **REQUIRED**	Patient Street Address	Use to report the patient's address, P. O. Box, City, State and zip code.
10 **REQUIRED**	Patient Birth date	Required format = MM/DD/CCYY
11 **REQUIRED**	Patient Sex	Field should be reported as either "F" or "M".

12 **REQUIRED**	Admission Date	Cannot be later than 'From' date of Form Locator 6. Format = MM/DD/YY
13 **OPTIONAL**	Admission Hour	Used to report the time a patient entered a facility or institution.
14 **REQUIRED**	Admission Type	This code indicates the priority of the admission. 1 – Emergency 2 – Urgent 3 – Elective 4 – Newborn 5- Trauma Center 6-8 – Reserved for National Assignment 9 – Information Not Available
15 **REQUIRED**	Admission Source	This field is used to report the source of a referral. 1 – Physician Referral 2 – Clinic Referral 3 – Managed Care Plan Referral 4 – Transfer from a Hospital (or different facility) 5 – Transfer from a SNF 6 – Transfer from Another Health Care Facility 7 – Emergency Room 8 – Court/Law Enforcement 9 – Information Not Available A – Transfer from a Critical Access Hospital B – Transfer from Another Home Health Agency C – Readmission to Same Home Health Agency D – Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer. E – Z – Reserved from National Assignment
16 ***OPTIONAL**	Discharge Hour	This field reports the time a person discharges. *It is only required when billing for date of death, using 224 revenue code for late discharge.
17 **REQUIRED**	Patient Status	Valid Code 30—Still a Patient or Expected to Return 20—Expired (deceased) 07----Left against medical advice 06----Discharged/Transferred to home under care of organized home health service organization in anticipation of covered skills care 05—Discharged to another type of Institution (PACE, hospice, etc.) 04—Discharge/Transfer to Level I 03—Discharge/Transfer to Level II 02----Transferred to the hospital 01----Discharged
18 - 28 ***REQUIRED**	Condition Codes	This field describes conditions or events that apply to this billing period. *Required for cross over billing only
29 **NOT USED**	Accident State	Data entered will be ignored.
30 **NOT USED**	Untitled	Data entered will be ignored.
31-36 **REQUIRED** **(FL 35 & 36 Represent Occurrence Span Codes and Dates)**	Occurrence Codes and Date	Codes must be accompanied by dates. *51—Physician Last Certification/Re-certification Date *54—Physician Visit Date *The above mentioned codes are no longer valid per UB04 Manual. TennCare has addressed this issue with CMS and at this time are waiting for a set of alternate codes.
37 **NOT USED**	Untitled	Data entered will be ignored.
38 **OPTIONAL**	Responsible Party Name and Address	Used for claims that involve payers of higher priority than Medicare.
39 - 41	Value Codes and Amounts Required	Field is used to report codes related to dollar or unit amounts. 80 – Covered Days

REQUIRED		81 – Non-Covered Days 82 – Co-Insurance Days A1 – Medicare Part A Deductible A2 – Medicare Part A Co-Insurance B1 – Medicare Part B Deductible B2 – Medicare Part B Co-Insurance
42 rows 1-22 **REQUIRED**	Revenue Code	Relevant Revenue Codes are used in this field including 001—Indicating Total Charges, must be placed at the bottom of the column.
43 **NOT REQUIRED**	Revenue Code Description	This field is used to describe the service if a provider chooses to do so (example: Room and Board).
44 **REQUIRED**	HCPCS/Rate/HIPPS Code	This field is used to enter the HCPCS codes of services provided. For inpatient use, the accommodation rate can be reported here.
45 **REQUIRED**	Service Dates	Used to report the date(s) of service(s) that each reported revenue code or HCPCS was provided.
46 **REQUIRED**	Service Units	Enter the number of units provided for the statement covered period for each reported Revenue or HCPCS.
47 **REQUIRED**	Total Charges	Enter the total charges for each Revenue or HCPCS code.
48 **REQUIRED**	Non-Covered Charges	This field is used to report the total of non-covered charges pertaining to relevant revenue codes.
49 **NOT USED**	Untitled	Data entered will be ignored.
Line 23 **REQUIRED**	Page___of____ Creation Date	If billing requires the use of multiple UB04 forms, information for all items on line 23 must be reported on all pages. (Creation date is the date the form was filled out)
50 **(A, B & C)** **REQUIRED**	Payer Identification	If Medicaid is the primary payer, Medicaid will be entered on the form. Additional payers will be listed in the order in which they paid. A – Primary B – Secondary C – Tertiary
51 **A –REQUIRED** **B – SITUATIONAL** **C – SITUATIONAL**	Health Plan ID	This field is used to report the national health plan identifier when one is established; otherwise report the "number" Medicare has assigned.
52 **(A, B & C)** **REQUIRED**	Release of Information	Valid codes for these fields are "Y" – provider has on file a singed statement permitting it to release data to other organizations in order to adjudicate the claim. (Most common used code) "I" – Indicates Informed Consent to release medical information for conditions or diagnoses regulated by federal statues. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA privacy rule by requiring a signature be collected. (Least common used code)
53 **NOT USED**	Assignment of Benefits Certification Indicator	Data entered will be ignored.
54 **(A, B & C)** **SITUATIONAL**	Prior Payments	Required only if another payer source is involved. If no prior payments, leave blank.
55 **(A, B & C)** **OPTIONAL**	Estimated Amount Due From Patient	This field is usually not applicable to Medicaid patients. However, if a non-covered Medicaid service is billed, this field may be used to report the amount of the non-covered Medicaid service.
56 **REQUIRED**	National Provider ID (NPI)	Required effective 5/23/2007 to be reported on all billing (electronic, paper, etc.)
57 **SITUATIONAL**	Other Provider ID (primary, secondary and/or tertiary)	Use this field to report other provider identifiers as assigned by a health plan (legacy provider ID's)
58 **(A, B & C)**	Insured's Name	The name must be the same as it appears on the ID card. (Last name, First name)

REQUIRED		
59 **(A, B & C)** **REQUIRED**	Patient's Relationship to Insured	Code used to identify patient to insured. 01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 – Organ Donor 53 – Life Partner G8 – Other Relationship
60 **(A, B & C)** **REQUIRED**	MID Number or SSN	Enter the unique identification number exactly as shown on the Medicaid ID card.
61 **(A, B & C)** **SITUATIONAL**	Insurance Group Name	This field is for patients who have a Third Party payer, to report the name of the group.
62 **(A, B & C)** **SITUATIONAL**	Insurance Group Number	This field is for patients who have a Third Party payer, to report the group number.
63 **SITUATIONAL**	Treatment Authorization Code	This field is used to report a prior authorization or referral number assigned by a payer.
64 **SITUATIONAL**	Document Control Number (DCN)	The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.
65 **SITUATIONAL**	Employer Name	This field is used to report the employer.
66 & 67 **(67 A-Q)** **REQUIRED**	Principal Diagnosis Code Other Diagnosis Codes	Enter the valid ICD-9-CM code.
68 **NOT USED**	Not Used	Data entered will be ignored.
69 **REQUIRED**	Admitting Diagnosis	Enter the diagnosis to identify the reason for admission.
70 **(A-C)** **SITUATIONAL**	Patient's Reason for Visit	Required for all un-scheduled outpatient visits for outpatient bills.
71 **NOT USED**	Prospective Payment System Code	Data entered will be ignored.
72 **NOT USED**	External Cause of Injury Codes	Data entered will be ignored.
73 **NOT USED**	Not Used	Data entered will be ignored.
74 **(74 A-E)** **SITUATIONAL**	Principal Procedure Code and Date 74 A-E – Other Procedure Codes and Dates	Required on inpatient claims when procedures must be reported. Not used on outpatient claims. Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims.
75 **NOT USED**	Not Used	Data entered will be ignored.
76 **SITUATIONAL**	Attending Provider Name and Identifiers (including NPI)	Required when claim/encounter contains any services other than nonscheduled transportation services. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported on this claim/encounter. Secondary Identifier Qualifiers: 0B – State License Number 1G – Provider UPIN Number G2 – Provider Commercial Number

77 **SITUATIONAL**	Operating Provider Name and Identifiers (including NPI)	Required when a surgical procedure code is listed on this claim. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s). Secondary Identifier Qualifiers: 0B – State License Number 1G – Provider UPIN Number EI – Employer's Identification Number SY – Social Security Number
78 & 79 **SITUATIONAL**	Other Provider Name and Identifiers (including NPI)	The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim. Provider Type Qualifier Codes/Definitions/Situational Usage Notes: DN – Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. ZZ – Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. 82 – Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim (e.g., a Medicaid clinic bill or Critical Access Hospital claims). Secondary Identifier Qualifiers: 0B – State License Number 1G – Provider UPIN Number EI – Employer's Identification Number SY – Social Security Number
80 **SITUATIONAL**	Remarks	For DME billings the provider shows the rental rate, cost and anticipated months of usage so that the provider's FI may determine whther to approve the rental or purchase of equipment. Where Mdicare is not the primary payer because WC, automobile medical, no fault, liability insurer or an EGHP is primary, the provider enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.
81 **SITUATIONAL**	Code-Code	To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set. Code List Qualifiers: 01-A0 – Reserved for National Assignment A1 – National Uniform billing Committee Condition Codes – not used for Medicare A2 - National Uniform billing Committee Occurrence Codes – not used for Medicare A3 - National Uniform billing Committee Occurrence Span Codes – not used for Medicare A4 - National Uniform billing Committee Value Codes – not used for Medicare A5 – B0 – Reserved for National Assignment B3 – Health Care Provider Taxonomy Code Code Source: ASC X12 External Code Source 682 (National Uniform Claim Committee) B4-ZZ – Reserved for National Assignment

HCPCS Codes

The HCPCS (Healthcare Common Procedure Coding System) contains alphanumeric codes used to identify those coding categories not included in the American Medical Association's CPT-4 codes.

See Attachment A for a list of approved HCPCS codes.

Other Features & Functionality

Please refer to Long Term Care – User Manual for information about additional features and functionality.

Comments Questions and Answers

Attachment A

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

HCPCS	Modifier	Service Description
S5102		Adult Day Care
T2030		Assisted Care Living Facility
T2029	U4	Assistive Technology
T2022	U3	Case Management – ends 10/31/07
T2022		Initial Intake Case Management Visit – effective 11/01/07
T2022	U1	Monthly Face-to-Face Case Management Visit(s) – effective 11/01/07
T2022	U2	Other Monthly Case Management Visits – effective 11/01/07
S5170		Home Delivered Meals
S5130	U1	Homemaker
S5150		In-Home Respite
S9125	U1	In-Patient Respite
S5165		Minor Home Modifications
S5125		Personal Care Attendant
S9122	U2	Personal Care Services
S5160		Personal Emergency Response System Installation
S5161		Personal Emergency Response System Monthly Fee
S5121	U1	Pest Control

Attachment B – UB04 Claim Form

Program Integrity – Fraud and Abuse

- Deficit Reduction Act of 2005

Effective 1/1/07 – All health care providers that receive or make annual Medicaid payments of $5 million or more per year, are required to educate employees, contractors or agents about certain fraud and abuse laws.

- Federal False Claims Act
    - Submitting or causing to be submitted a false claim to the United States Government for payment or approval;
    - Making, using or causing to be made or used, a false record or statement to get a false claim paid or approved by the Government;
    - Conspiring to get a false claim allowed or paid by the Government; or
    - Making, using or causing to be made or used, a false record to conceal, avoid or decrease an obligation to pay money or transmit property to the Government.

- Whistleblower Protection
    - Prohibits retaliation against public employees who report official wrongdoing, along with possible rewards for the Whistleblower.

- Tennessee Medicaid False Claims Act (TMFCA)
    - State law designed to apply solely to false claims under the Medicaid program.
    - Liability and Damages – Actions that violate TMFCA
        - Submitting a false claim for payment
        - Making or using a false record to get a false claim paid
        - Conspiring to make a false claim or get one paid, or
        - Making or using a false record to avoid payments owed.
        - Benefiting from a mistakenly submitted false claim that is not disclosed soon after he or she discovers the error.

Both Federal and State False Claims Acts may impose a civil penalty per claim, plus three times the amount of damages to the state may be imposed for violations.

Please call, fax, e-mail or mail to:
Vicki Guye, Chief Audit Executive
TennCare Internal Audit
615-507-6407

Fax: 615-253-5441
Vicki.Guye@tn.gov
310 Great Cirlce Road
Nashville, TN 37243
OR
Call or Fax:
The Office of Inspector General
TennCare Fraud and Abuse Hot-Line
1-800-433-3982
Fax: 615-256-3852
YOU ARE NOT REQUIRED TO PROVIDE YOUR NAME