

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

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## AIDS Waiver Program Billing Examples

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Examples in this section are to help providers bill AIDS Waiver Program services on the *UB-04* claim form. Refer to the *AIDS Waiver Program* section in this manual for general policy information. Refer to the *UB-04 Completion: Outpatient Services* section of this manual for instructions to complete claim fields not explained in the following example. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

**Billing Tips:** When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Remarks* field (Box 80) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

**AIDS Waiver Services:  
Adult Claim**

*Figure 1. AIDS waiver services: adult claim.*

*This is a sample only. Please adapt to your billing situation.*

In this case, an adult woman receives in-home AIDS Waiver services for the month of July 2010. The attendant care and homemaker services are billed using the “from-through” format. The administrative expenses, case management, skilled nursing, equipment/home adaptation and nutritional counseling services are billed per-line.

Enter the two-digit facility type code “33” (Home Health – Outpatient) and one-character claim frequency code “1” as “331” in the *Type of Bill* field (Box 4).

On claim line 1, enter the recommended revenue code (0552) in the *Revenue Code* field (Box 42). Enter a description of the service rendered (skilled nursing care – RN) in the *Description* field (Box 43) and the corresponding HCPCS procedure code with modifier (G0154TD) in the *HCPCS/Rate* field (Box 44). Enter the date of service (July 4, 2010) in the *Service Date* field (Box 45) as 070410. A 16 is entered in the *Service Units* field (Box 46). Enter the usual and customary charges in the *Total Charges* field (Box 47, line 23).

Claim lines 2 and 3 illustrate how to bill the “from-through” method for attendant care. On claim line 2 enter the description of the service rendered (attendant care) in the *Description* field (Box 43) and the amount of time the service was rendered daily. Enter the beginning date of service (July 1, 2010) in the *Service Date* field (Box 45) as 070110. No other information is entered on this claim line.

On claim line 3, enter the recommended revenue code 0572 in the *Revenue Code* field (Box 42). Enter the specific days the services were rendered (7/1, 2 and 3) in the *Description* field (Box 43) and the corresponding HCPCS code for the services (G0156) in the *HCPCS/Rate* field (Box 44). Enter the “through” date of service (July 3, 2010) in the *Service Dates* field (Box 45) as 070310.

Enter a 96 in the *Service Units* field (Box 46) for G0156. This is to indicate 8 hours or 32 15-minute increments of attendant care for three (3) days (since G0156 is billed in 15-minute increments, 8 hours x 4 = 32 x 3 days = 96). Enter the usual and customary charges in the *Total Charges* field (Box 47, line 23).

Complete any remaining attendant care lines similarly, keeping in mind that the total units per claim line may not exceed 99.

On claims lines 7, 8 and 9, the homemaker services (code S5130) also are billed in the “from-through” method in 15-minute units. In this example, a third claim line (in addition to the service description and specific service dates) has been added to show the total number of hours the homemaker traveled to and from the job (travel 3 hours total). For additional information about billing for travel, refer to the *AIDS Waiver Program Billing Codes and Rates* section in this manual.

No *Treatment Authorization Request* (TAR) is required for the equipment and minor home adaptation services that are billed on this claim (code T2028) because the services do not meet the criteria for State plan coverage. For additional information, refer to “ ‘Specialized Medical Equipment and Supplies’ and Physical Adaptations to the Home (HCPCS Codes S5165, T2028 and T2029” in the *AIDS Waiver Program* section of this manual.

Enter “O/P Medi-Cal” to indicate the type of claim and payer in the *Payer Name* field (Box 50).

The NPI assigned to the AIDS Waiver Program provider number is placed in the *NPI* field (Box 56).

Enter the recipient’s identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card in Box 60. Do not enter the Waiver Agency ID number.

Enter ICD-9-CM diagnosis code 042 (human immunodeficiency virus [HIV] disease) in Box 67. Leave all other diagnosis code fields blank.

In this example, the statement in the *Remarks* field (Box 80) concerning eligibility (Proof of Eligibility Received. See Attached POS Printout) is optional. The provider has attached a Point of Service (POS) printout to the claim to help facilitate payment.



**AIDS Waiver Services:  
Pediatric Claim**

*Figure 2. AIDS waiver services: pediatric claim.*

*This is a sample only. Please adapt to your billing situation.*

In this case, a boy receives in-home AIDS Wavier services for the month of July 2010.

Enter the two-digit facility type code “33” (Home Health – Outpatient) and one-character claim frequency code “1” as “331” in the *Type of Bill* field (Box 4).

On claim line 1, enter the recommended revenue code 0583 in the *Revenue Code* field (Box 42). Enter the description of the service rendered (case management) in the *Description* field (Box 43) and the corresponding HCPCS procedure code (T2022) in the *HCPCS/Rates* field (Box 44). Enter the date of service (July 1, 2010) in the *Service Date* field (Box 45) as 070110. A “1” is entered in the *Service Units* field (Box 46) for T2022 because case management is reimbursed once at a flat calendar month rate. Enter the usual and customary charges in the *Total Charges* field (Box 47, line 23). Complete the remaining claim lines similarly.

Note also that the skilled nursing care code – LVN (G0154TE) entry includes the number of hours in 15-minute increments the service was rendered and the total travel time in the *Description* field (Box 43).

Enter “O/P Medi-Cal” to indicate the type of claim and payer in the *Payer Name* field (Box 50).

The NPI assigned to the AIDS Waiver Program provider number is placed in the *NPI* field (Box 56).

Enter the recipient’s identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card in Box 60. Do not enter the Waiver Agency ID number.

Enter ICD-9-CM diagnosis code 042 (human immunodeficiency virus [HIV] disease) in Box 67. Leave all other diagnosis code fields blank.

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1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL <b>331</b>	
8 PATIENT NAME a <b>DOE JOHN</b>				9 PATIENT ADDRESS a			
10 BIRTHDATE <b>08242000</b>		11 SEX <b>M</b>		12 DATE		13 ADMISSION 13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT <b>80</b>	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35		36		37	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	0583	CASE MANAGEMENT SKILLED NURSING CARE –	T2022	070110	1	229 17	
2		LVN 3 HOURS					
3							
4	0522	TRAVEL 1 HOUR TOTAL	G0154TE	070110	16	117 76	
5	0562	PSYCHOTHERAPY	90806	070110	2	102 00	
6	0580	ADMINISTRATIVE EXPENSES	T2025	070110	1	170 28	
7		ATTENDANT CARE		070110			
8		4 HOURS DAILY – 7/1 2 4 7 11					
9	0572	TRAVEL 4 HOURS TOTAL	G0156	071110	96	454 08	
10	0589	NON-EMERG. MEDICAL TRANS	T2003	070110	1	40 00	
11	0580	FOSTER CARE SUPPLEMENT	T2026	070110	1	50 00	
12		NUTRITIONAL SUPPLEMENTS/					
13	0589	HOME-DELIVERED MEAL	S5170	070110	1	50 00	
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50 PAYER NAME A O/P MEDI-CAL		51 HEALTH PLAN ID		52 REL. INFO		53 ASO BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 1213 29		56 NPI 0123456789		57 OTHER PRV ID	
58 INSURED'S NAME		59 P. REL.		60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 042		67		68		69	
69 ADMIT DX		70 PATIENT REASON DX		71 FPS CODE		72 ECI	
73		74		75		76	
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