

Home Health Agencies

Introduction

Purpose

The purpose of this module is to provide billing information applicable to Home Health Agencies (HHA) Services for Medi-Cal recipients and California Children's Services (CCS) clients. Restricted eligibility, aid codes, claim submission, documentation and the *Treatment Authorization Request* (TAR) are explained. Also included is a crosswalk from Healthcare Common Procedure Coding System (HCPCS) local Level III codes to Health Insurance Portability and Accountability Act (HIPAA)-compliant HCPCS Level II national codes.

Objectives

- Identify Medi-Cal HHA policy for Medi-Cal recipients and CCS clients
- Review HHA services
- Discuss the HIPAA-mandated changes to the billing requirements for the HHA conversion
- Examine the policy and billing requirements for HHA
- List the HHA HCPCS Level II national and revenue codes
- Detail appropriate HHA documentation requirements
- Describe the field requirements of the *UB-04* claim forms and billing issues with HHA claim examples

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Aid Codes Master Chart (aid codes)

OBRA and IRCA (obra)

Part 2

Home and Community-Based Services (HCBS) (home)

Home and Community-Based Services (HCBS) Billing Codes and Reimbursement Rates
(home cd)

Home Health Agencies (HHA) (home hlth)

Home Health Agencies (HHA) Billing Codes and Reimbursement Rates (home hlth cd)

Home Health Agencies (HHA) Billing Examples (home hlth ex)

UB-04 Completion: Outpatient Services (ub comp op)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

NOTES

Description

HHA is an outpatient benefit prescribed by a physician and provided at the recipient's home in accordance with a written treatment plan. The plan is reviewed by a physician every 60 days. The plan must indicate a need for one or more of the following services:

- Part-time or intermittent skilled nursing service by licensed nursing personnel
- In-home medical care services as defined in the *Welfare and Institutions Code* (W&I Code) Section 14132(t)
- Physical, occupational or speech therapy
- Medical social services
- Home health aide services
- Medical supplies other than drugs and biologicals
- Other home health services
- The use of medical appliances, provided for under an approved treatment plan

NOTE

Durable Medical Equipment (DME), such as an infusion pump, is reimbursable only when billed by a valid DME provider. DME cannot be billed by an HHA provider.

NOTES

Policies

HIPAA requires the use of revenue codes for billing and adjudication.

Effective for dates of service on or after June 1, 2016, HCPCS Level III local codes for HHA are discontinued and replaced with 10 new HIPAA-compliant codes shown in the following table.

There will be no change in rates for home health services in relation to the code conversion. The code conversion is date-of-service driven.

- Claims submitted with revenue codes in the revenue code field and a HCPCS Level II national home health service code in the HCPCS field for dates of service prior to June 1, 2016, will not be reimbursable.
- Claims submitted without a revenue code for dates of service on or after June 1, 2016, will be denied.

Discontinued HCPCS Code	Current CPT-4/HCPCS Level II Code Description	Revenue Code Description
Z6900	G0154 (direct skilled nursing services of a licensed nurse [LPN or RN] in the home health or hospice setting, each 15 minutes. Includes supplies that are used as part of the treatment visit.	0551 (skilled nursing/visit)
Z6902	G0156 (services of home health/hospice aide in home health or hospice setting, each 15 minutes)	0571 (aide/home health/visit)
Z6904	G0151 (services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes)	0421 (physical therapy/visits)
Z6906	G0152 (services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes)	0431 (occupational therapy/visit)
Z6908	G0153 (services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes)	0441 (speech pathology/visit)

Discontinued HCPCS Code	Current CPT-4/HCPCS Level II Code Description	Revenue Code Description
Z6910	G0155 (services of clinical social worker in home health or hospice setting, each 15 minutes)	0561 (medical social services/visit)
Z6914	G0162 (skilled services by a registered nurse [RN] in the delivery of management & evaluation of the plan of care; each 15 minutes)	0583 (visit/home health/ assessment)
Z6916	G0162 (skilled services by a registered nurse [RN] in the delivery of management & evaluation of the plan of care; each 15 minutes)	0589 (visit/home health/other)
Z6918	99600 (unlisted home visit service or procedure). The code combination 99600/0589 is for billing services. Respiratory therapist services can be authorized and billed under 99600.	0589 (visit/home health/other)
	A9999 (miscellaneous DME supply or accessory, not otherwise specified). The code combination A9999/0270 is for billing supplies.	0270 (medical/ surgical supplies and devices, general classification)
Z6920	99501 (home visit for postnatal assessment and follow-up care). For follow-up of early Obstetrics (OB) discharge. This is an OB service, not a typical home health service.	0580 (visit/home health)
	99502 (home visit for newborn care and assessment). For follow-up of early Obstetrics (OB) discharge. This is an OB service, not a typical home health service.	

Frequency Limitations

Revenue Code	HCPCS Level II/CPT-4 Code	Frequency Limitations
0270	A9999	As authorized
0421	G0151	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0431	G0152	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0441	G0153	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0551	G0154	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0561	G0155	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0571	G0156	As authorized
0580	99501	Once in six months
	99502	Once in six months
0583	G0162	Four in six months (1 hour)
0589	G0162	Four in six months (1 hour)
	99600	As authorized

Home Health Agencies Billing

Physician Treatment Plan

Authorization requests for services beyond the case evaluation require prior approval and must include a written treatment plan that will be approved and signed by a physician within 30 working days of the treatment plan.

Since the ordering physician has 30 working days to sign a written treatment plan, an authorization request may be submitted to the TAR Processing Center with an unsigned written treatment plan. The unsigned written treatment plan must have a physician's verbal order for services, taken and recorded by a health care professional at the time services are ordered. A healthcare professional may be a registered nurse, qualified therapist, social worker or any other health professional responsible for furnishing or supervising care.

The treatment plan must include:

- The principal diagnosis and significant associated diagnoses
- Prognosis
- Date of onset of the illness
- Specific types of services to be rendered by each discipline
- Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals
- The extent to which HHA care has been previously provided and benefits or improvements demonstrated by such care
- A description of the home situation, to include whether assistance is available from household members, homemakers, attendants or others

A re-authorization request must include a statement describing the recipient's progress toward achieving the therapeutic goals.

NOTE

Upon request, the written treatment plan must be available to Department of Health Care Services (DHCS) staff by providing HHA documenting evidence of the ordering physician's signature within 30 working days of the treatment plan date.

TAR Requirements

Effective for dates of service on or after June 1, 2016, TARs containing HCPCS Level III local home health codes will no longer be permitted.

TARs submitted with dates of service on or after June 1, 2016, require the HCPCS Level II national home health codes.

NOTE

All home health services billing HCPCS Level II national codes require an approved TAR on or after June 1, 2016.

All TARs with home health local codes and a combination of HCPCS Level III and HCPCS Level II procedure codes, regardless of status (approved, retroactive or deferred) will be end-dated for dates of service on or after June 1, 2016.

Monthly case evaluation, extension of treatment plan and skilled care services (revenue code 0589 and HCPCS code G0162) are not subject to authorization; however any other skilled care services billed with these codes must be accompanied by an approved TAR on a separate claim form.

For dates of service on or after June 1, 2016, home health billing policy is updated to accommodate the following HCPCS Level II codes. The HCPCS codes are shown with their corresponding revenue code; however, only the HCPCS code will be used for TAR purposes.

Revenue Code	HCPCS Level II/CPT-4 Code	Authorization
0270	A9999	TAR required
0421	G0151	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
0431	G0152	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
0441	G0153	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
0551	G0154	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)

Revenue Code	HCPCS Level II/CPT-4 Code	Authorization
0561	G0155	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
0571	G0156	TAR required
0580	99501	TAR <u>not</u> required
	99502	TAR <u>not</u> required
0583	G0162	TAR <u>not</u> required
0589	G0162	TAR <u>not</u> required
	99600	TAR required

TAR Completion and Submission Information

Medi-Cal strongly encourages the use of an electronic Treatment Authorization Request (eTAR). Listed below are the benefits of submitting eTARs and tips on submitting paper TARs.

eTARs

- Faster response time
- Less expensive and less time consuming
- No mail delays or postage
- Check status of eTARs online anytime

Paper TARs

- TARs must be typed
- Include necessary medical justification
- Verify TAR information (provider number/National Provider Identifier [NPI])
- Include an original signature

Verify the status of the TAR through the Provider Telecommunications Network (PTN) at 1-800-786-4346 or on the Medi-Cal website (www.medi-cal.ca.gov).

Same Day Services

Skilled Care Services

If it is necessary to perform skilled care services (HCPCS codes G0151 – G0155) on the same date of service as the initial or six-month case evaluation (revenue code 0583 and HCPCS code G0162), both services must be billed on the same claim.

Service	HCPCS Code	Revenue Code
Physical therapy	G1051	0421
Occupational therapy	G0152	0431
Speech therapy	G0153	0441
Skilled nursing	G0154	0551
Medical social services	G0155	0561

When billing for one of the skilled care services on the same date as the initial or six-month case evaluation, both the evaluation and the skilled care services are reimbursable without authorization. If the skilled care service is billed separately, authorization is required.

NOTE

Only one skilled care service may be billed in conjunction with the initial evaluation.

Mother and Baby

- Services performed for a mother and baby on the same day require a separate *UB-04* claim form and a separate TAR for each recipient.
- HHA providers who render services to a mother and her newborn(s) during the neonatal period (month of delivery and subsequent month) may be reimbursed without authorization for only one initial skilled nursing visit (revenue code 0551 and HCPCS code G0154).
- A case evaluation and initial treatment plan (revenue code 0583 and HCPCS code G0162) is reimbursable for the mother without authorization.
- A case evaluation and initial treatment plan (revenue code 0583 and HCPCS code G0162) for the newborn using the mother's Medi-Cal ID number may be reimbursed without authorization when it is performed on a different date than the mother's case evaluation and initial treatment plan.
- If more than one visit is necessary or if services are rendered to mother and infant on the same date of service for the month of birth and the following month and the infant is using the mother's ID, authorization is required.

When completing claims, do not enter the decimal points in the ICD-10-CM diagnosis codes or dollar amounts. If requested information does not fit properly in the *Remarks* field (Box 80) of the claim, type it on an 8 ½ x 11-inch sheet of paper and attach it to the claim.

Home Health Psychiatric Nursing Services

HHA services are excluded from coverage by the Mental Health Program (MHP) as set forth in the *California Code of Regulations* (CCR). However, home health psychiatric nursing is a skilled nursing service that may be provided by an HHA to a Medi-Cal recipient with a psychiatric illness or condition.

NOTE

HHA psychiatric nursing service visits require the submission of a TAR for approval. The TAR must be accompanied by a written plan of care approved by a physician every 62 days. See the *Home Health Agencies (HHA)* (home hlth) section in the Part 2 manual for authorization requirements.

The following are examples of psychiatric services that may be provided by a home health nurse:

- Make an initial evaluation using observation and assessment skills
- Evaluate, review and teach the use of medications, emphasizing compliance
- Administer IM or I.V. medication, if necessary
- Manage situational (or other) crises; perform suicidal assessments, as necessary
- Provide psychotherapeutic assessments as ordered by the physician, which may include supportive counseling, behavior modification (for obsessive-compulsive behaviors such as hand washing) and cognitive retraining (positive thinking process)
- Provide psychological education such as teaching/training with disease process, symptom and safety management, coping skills and problem solving

Home Health Aide Services

Home health aide services (revenue code 0571 and HCPCS code G0156) are both Medicare and Medi-Cal benefits. These services may include personal care and household services that must be billed as part of a physician-approved treatment plan and must be supervised by a registered nurse therapist.

Personal care services include:

- Ambulation
- Bathing
- Catheter site care
- Feeding assistance
- Grooming
- Medical assistance
- Prescribed exercise assistance
- Range of motion exercises
- Skin care
- Transfers out of bed

Certain household services may also be included in the visit if they are incidental to medically necessary services and do not substantially increase the home health aide's service time.

Medical Supplies

Medical supplies sent to Medi-Cal recipients by HHA personnel may be covered as separately reimbursable items subject to authorization. Supplies are separately reimbursable if:

- They are not used as part of a treatment visit (that is, they are left with the recipient for later use)
- They are provided in accordance with the recipient's written treatment plan

Under Medi-Cal, the medical supply used in connection with the treatment visit (for example, bandages used to change dressings) is included in the reimbursement for the nursing visit. The reimbursement is intended to include the cost of incidental supplies. Medical supplies can be considered separately reimbursable only when they are left with the recipient.

Medical supplies are:

- Subject to authorization regardless of their cost
- Billed with revenue code 0270 and HCPCS code A9999
 - Billed "By Report"
 - An invoice, an itemized list and a TAR should be attached to the claim
- Treatment plan must state these supplies are consistent with the treatment proposed

Other HHA Services

Other services provided by HHA personnel that do not apply to any of the previous categories may be separately reimbursable and subject to authorization.

Example: Respiratory therapist services should be billed with CPT-4 code 99600 and revenue code 0589.

- Must be billed "By Report"
- An invoice, an itemized list and a TAR should be attached to the claim

Billing Examples

The examples in this module are to assist providers in billing HHA services on the *UB-04* claim form. For general policy information, refer to the *Home Health Agencies (HHA)* (home hlth) section in the Part 2 manual. Refer to the *UB-04 Completion: Outpatient Services* (ub comp op) section in the Part 2 manual for instructions to complete claim fields not explained in the following example. Examples are samples only. Please adapt to your billing situation.

Skilled Nursing Services

Figure 1. A physician has prescribed in-home medical care for a recipient who requires intermittent injections. The recipient has a written plan of care that is reviewed by the physician every 60 days. The agency that renders the services submits claims monthly. The skilled nursing visits are billed in the “from-through” format and require authorization.

NOTE

HHA claims do not require condition, occurrence or value code information (Boxes 18 – 28, 31 – 37 and 39 – 41).

On claim line 1:

- Enter the description of the service rendered (skilled nursing visits) in the *Description* field (Box 43).
- Enter the “from” date of service (June 1, 2016) in six-digit format as 060116 in the *Service Date* field (Box 45).

On claim line 2:

- Enter code “0551” in the *Revenue Code* field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the specific days the services were rendered (6/1, 5, 8, 13, 20, 26 and 30) in the *Description* field (Box 43).
- Enter the procedure code (G0154) in the *HCPCS/Rate* field (Box 44).
- Enter the “through” date of service (June 30, 2016) in six-digit format as 063016 in the *Service Date* field (Box 45).
- Enter a “7” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 3:

- Enter code “0589” to indicate that this is a home health visit in the *Revenue Code* field (Box 42).
- Enter the description of the service rendered (administered drugs) in the *Description* field (Box 43).
- Enter the procedure code (99600) in the *HCPCS/Rate* field (Box 44).
- Enter the service date in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 4:

- Enter code “0270” in the *Revenue Code* field (Box 42) to indicate that this home health visit involved providing medical supplies.
- Enter the description of the service rendered (medical supplies) in the *Description* field (Box 43).
- Enter the procedure code (A9999) in the *HCPCS/Rate* field (Box 44).
- Enter the service date in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 23:

- Enter code “001” to designate that this is the total charge line in the *Revenue Code* field (Box 42).
- Enter the total of all charges in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code “33” (home health – outpatient) and one-character claim frequency code “1” as “331.”
50	Payer Name	Enter “O/P MEDI-CAL” to indicate the type of claim and payer.
56	NPI	Enter the HHA’s NPI.
63	Treatment Authorization Codes	Enter the 11-digit TAR number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of “0” is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the rendering provider’s NPI.
80	Remarks	HCPCS code A9999 must be billed “By Report,” which requires an invoice, itemized list of supplies and a TAR to be attached to the claim. Indicate that the claim has attachments. Refer to the <i>Home Health Agencies (HHA)</i> (home hlth) section of the Part 2 provider manual for additional code A9999 billing instructions.

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2		3a PAT. CNTRL # b. MED. REC. #		4 TYPE OF BILL 331	
8 PATIENT NAME a DOE, JOHN			9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980	11 SEX M	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR
31 OCCURRENCE DATE	32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0551	SKILLED NURSING VISITS 6/1, 5, 8, 13, 20, 26, 30	G0154	060116	7	770 00	
0589	ADMINISTERED DRUGS	99600	060116	1	100 00	
0270	MEDICAL SUPPLIES	A9999	063016	1	25 00	
001	PAGE OF	CREATION DATE	TOTALS	895 00		
50 PAYER NAME O/P MEDI-CAL	51 HEALTH PLAN ID	52 REL. INFO	53 ASST. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 895 00	56 NPI 0123456789
58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID 90000000A95001	61 GROUP NAME	62 INSURANCE GROUP NO.		
63 TREATMENT AUTHORIZATION CODES 01234567890	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME				
66 DX D1D1D1D 0	67	68				
69 ADMIT. DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73		
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 REMARKS
		1234567890				SEE ATTACHMENTS

Figure 1: Skilled Nursing Services

Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit

Figure 2. A physician has prescribed in-home medical care for a patient who had a stroke. The patient has a written plan of care that is reviewed by the physician every 60 days. This claim is submitted for initial case evaluation plus treatment plan services. No TAR is required for a skilled nursing visit rendered on the same day as the initial evaluation (HCPCS Level II code G0162). These services are billed on the same claim form.

NOTE

HHA claims do not require condition, occurrence or value code information (Boxes 18 – 28, 31 – 37 and 39 – 41).

On claim line 1:

- Enter code “0583” in the *Revenue Code* field (Box 42) to indicate that this is a visit/home health assessment.
- Enter the description of the service rendered (Initial case evaluation) in the *Description* field (Box 43).
- Enter the procedure code (G0162) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (June 1, 2016) in six-digit format as 060116 in the *Service Date* field (Box 45).
- Enter a “1.” in the *Service Units* field (Box 46). Quantities must be billed in whole units.
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 2:

- Enter code “0551” in the *Revenue Code* field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the description of the service rendered (skilled nursing visit) in the *Description* field (Box 43).
- Enter the procedure code (G0154) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (June 1, 2016) in six-digit format as 060116 in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46). Quantities must be billed in whole units.
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 23:

- Enter code “001” in the *Revenue Code* field (Box 42) to designate that this is the total charge line.
- Enter the total of all charges in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "33" (home health – outpatient) and one-character claim frequency code "1" as "331."
50	Payer Name	Enter "O/P MEDI-CAL" to indicate the type of claim and payer.
56	NPI	Enter the HHA's NPI.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the rendering provider's NPI.

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2		3a PAT. CNTL # b. MED. REC. #		4 TYPE OF BILL 331	
8 PATIENT NAME a DOE, JOHN			9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980	11 SEX M	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR
17 STAT	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 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN FROM	37 OCCURRENCE SPAN THROUGH
38	39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT	42	43	44
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1 0583	INITIAL CASE EVALUATION	G0162	060116	1	60 00	
2 0551	SKILLED NURSING VISIT	G0154	060116	1	42 00	
3						
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23	001	PAGE	OF	CREATION DATE	TOTALS	102 00
A	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASST. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
B	O/P MEDI-CAL					102 00
C	56 NPI	57 OTHER PRV ID	58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
A					90000000A95001	
B						
C						
A	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	66 DX	67	68
B				D1D1D1D		
C				O		
A	69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73	
B						
C						
A	74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI
B				1234567890		
C						
A	80 REMARKS	81CC a	82	83	84	85
B		b				
C		c				
A		d				

Figure 2: Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit