Keystone First
Community HealthChoices
200 Stevens Drive
Philadelphia, PA 19113

Keystone First
Community HealthChoices

TO: Keystone First Community HealthChoices (CHC) Nursing Facility Providers

DATE: September 2019

SUBJECT: NURSING FACILITY BILLING GUIDE

Dear Provider,

We want to make both public and non-public Nursing Facilities aware of the Keystone First CHC-specific requirements for accurate claim submission. These requirements are necessary for accurate and timely processing of your facility claims for room and board charges, respite services and exceptional durable medical equipment (DME) charges. Failure to adhere to the following guidelines may result in claim payment delay or denials.

Acceptable facility bill types

Item	Acceptable bill types
Bill type	21X
Bill type	26X
Bill type	65X

Billing facility days

When you are billing for Medicaid facility days, please adhere to the following guidelines:

Item	Billing facility days
Bill Rev Code	Bill all room and board charges with **Revenue (Rev) Code 0100** and the total days along with the facility specific per diem rate.
Patient pay	Bill **Value Code 23 and 66** if Participant patient pay is applicable. Value code 23 should be billed with gross patient pay responsibility. Value code 66 should reflect net patient pay. $0.00 is an acceptable amount for Value Code 66.
Value Code 80	Bill **Value Code 80** with the number of covered days. Add any other Value Code(s) applicable to Participant (i.e., 23, 25, 31, 34, 35).

Billing for non-covered days

When you are billing non-covered days, please adhere to the following guidelines:

Item	Non-covered days
Value Code	Bill **Value Code 81** with the number of non-covered days. Non-covered days include any days paid by other payer that would exclude us from any payment responsibility.
Condition Code	Enter condition code **X4-Medicare denial on file.**

Billing coinsurance days

When billing coinsurance days, please adhere to the following guidelines:

Item	Coinsurance days
Medicare prior payments	Show all **Medicare paid amounts for coinsurance days** on the claim as prior payments. This will allow the claim to coordinate payment between Medicare and Medicaid for the coinsurance days.
Bill Rev Code	Bill coinsurance days on **Room and Board Line** with **Rev Code 0100** with dates of service covered by Medicare **coinsurance.** If billing with other Room and Board charges, a separate line is needed to show coinsurance days. Include charges and units. Billed days may be billed at facility per diem rate.
Value Code	Bill **Value Code 82** with the number of coinsurance days.
Condition Code	Enter condition code **X2.**

PLEASE NOTE: WHEN BILLING FACILITY DAYS AND CO-INSURANCE DAYS ON SAME CLAIMS, PLEASE USE X2 CONDITION CODE.

Important reminders:

- Statement dates must equal Value Codes 80, 81, and 82 when billed.
- Value Codes 80 and 82 must have separate line items billed with appropriate Rev Codes that match values indicated for these Values Codes. Example: 15 facility days, and 5 coinsurance days would show with 2 lines billed, Rev Code 100 15 units, Rev Code 100 5 units.
- Total values billed with Value Code 80 and 82 must equal line item total units billed.

Billing for hospital reserve leave days

When you are billing hospital reserve leave days, please adhere to the following guidelines:

Item	Hospital reserve leave days
Leave limit	Hospital leave days are limited to **15 per hospitalization.**
Rate reimbursed	Hospital leave days are **reimbursed at 1/3 of your per diem rate**.

Bill Rev Code	Bill **Rev Code 0185** with number of leave days
Bill Occurrence Code	Bill **Occurrence Code 74** with date span matching date span participant was hospitalized.

Billing for therapeutic leave days

When you are billing for therapeutic leave days, please adhere to the following guidelines:

Item	Therapeutic leave days
Annual limit	Therapeutic leave days are limited to **30 days** per calendar year.
Rate reimbursed	Reimbursement will equal your **per diem rate**.
Bill Rev Code	Bill with **Rev Code 0183** with number of days

Value Codes

The following is a list of Value Codes used to identify deductions to the Participant's patient pay liability. Value Codes should be entered in numerical sequence. Enter a whole dollar amount in each form locator when using Value Codes 23 through 66. Enter days for Value Codes 80, 81 and 82.

Value Codes	
23	Gross Patient Pay Amount
25	Drug Deductions
31	Lifetime Other Medical Expenses (related to facility services)
34	Other Medical Expenses
35	Health Insurance Premiums
66	Net Patient Pay Amount
80	Facility Days (includes full days and leave days)
81	Non-Covered Days (days paid by other payers. Example: Full Medicare days, other insurance plans, or unpaid hospital days)
82	Coinsurance Days

Billing for respite days

When billing respite days please submit based on the below information. Respite services are paid at the contracted facility daily per diem rate.

- Respite services must be billed on a **CMS-1500 claim form** or submitted in an **835P format** when submitting electronically.
- Respite services should be billed with **HCPC code T1005**.
- Code T1005 is a 15 minute increment code. Bill four (4) units for every hour of respite care. Maximum number of units per day would be 96.
- Bill each day of respite care on separate line on CMS-1500 claim form.
- Reimbursement will be the same as facilities per diem rate.

Billing for exceptional DME
Please refer to the Exceptional DME Authorization and Billing Guidelines document on our website: www.keystonefirstchc.com → Providers → Claims and Billing → Additional Billing Information. This document explains that exceptional DME items should be billed by our contracted DME network providers. If you have any questions, please contact Provider Services at **1-800-521-6007**, or contact your Account Executive.

Billing for other medical expenses (OME)
You should continue to follow the Office of Long-Term Living (OLTL) guidelines for billing OMEs. These charges should be shown on the claim under **Value Code 31 or 34** based on Value Code definitions. We strongly encourage you to use our contracted network providers who may provide or perform historically billed OME services such as dental and vision.

Submitting corrected claims
The following are instructions for submitting corrected claims.

Item	Submitting corrected claims
Frequency	Corrected clams must be billed with **frequency 7**.
Claim number	The most recently processed claim number must be listed in **block 64** on the line matching CHC insurance information.

Claim submission instructions

Item	Claim submission instructions
Paper claim submission	**Mail to Claim Processing Department Keystone First CHC (no Medicare) at:** Keystone First CHC P.O. Box 7146 London, KY 40742-7146
Electronic claim submission	To submit claims electronically, contact: Change Healthcare Provider's Support Line at **1-800-845-6592**. If you currently use a clearinghouse to submit charges electronically confirm with them their ability to submit charges to Change Healthcare. Electronic Payer ID: **42344**
EDI questions	For general EDI questions please contact: EDI Technical Support Hotline at **1-877-234-2460** or by email at **edi.kfchc@keystonefirstchc.com**.

Claim filing deadlines

Item	Filing deadlines
Original invoices	Original invoices must be submitted to the Plan within 180 calendar days from the date services were rendered or compensable items were provided.
Re-submissions	Re-submission of previously denied claims with corrections and

	requests for adjustments must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.

Important Reminders

- Keystone First CHC is the payer of last resort. All other insurance carriers must be billed prior to submitting charges to Keystone First CHC. All standard UB04 billing requirements are necessary for accurate and timely processing of your facility claims for room and board charges.
- Claims must be billed with all OLTL required information for encounter acceptance. Claims processed and later identified as not meeting those requirements will be subject to recoupment and correct resubmissions.
- Original claims must be submitted to the Plan within 180 calendar days from the date services were rendered or compensable items were provided.
- Re-submission of previously denied claims or incorrectly processed claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date services were rendered or compensable items were provided. All resubmissions must be in accordance to corrected claim submission guidelines.

Questions	• If you have any questions regarding this notice, please contact Keystone First CHC Provider Services at **1-800-521-6007** or your Provider Account Executive. • For additional information related to claim submissions, please refer to our Claims Filing Guide located on our website at www.keystonefirstchc.com or your dedicated Provider Account Executive. • For any other questions or concerns please contact your Provider Account Executive.

Thank you for the care and services you provide to Keystone First CHC Participants.