Skilled Nursing Facility

Quick Reference

Billing Manual

Family Care & Pace/Partnership

Table of Contents

Introduction

It is the policy of Community Care to adjudicate provider claims in a timely and accurate manner.
To ensure that claims are paid to the provider according to the contractual agreement between the provider and Community Care.

In addition, it is the policy of Community Care to adjudicate 90% of all clean claims within 30 days of receipt and 99% of all clean claims within 90 days of receipt. The clean claim must be submitted within the timely filing limitation of the provider's contract with CCI.

Programs

Family Care:

A capitated Medicaid managed care program for the delivery of all Medicaid long-term care services. Members enrolled in Family Care may be eligible at a Wisconsin Medicaid nursing home-certifiable level of care or at a non-nursing home level of care. One of these functional levels of care is required as a condition of eligibility.

PACE or a **Program of All-inclusive Care for the Elderly:**

A capitated integrated Medicaid and Medicare managed care program very similar to Partnership; accordance with 42 CFR § 460.6, Definitions. All members enrolled in PACE have a Wisconsin Medicaid nursing home-certifiable level of care, which is required as a condition of eligibility. As a fully integrated program, all supports and services – whether Medicare or Medicaid benefits – are delivered through the PACE model design identified in the contract.

Partnership:

Partnership is the Wisconsin Family Care Partnership program. A capitated integrated Medicaid and Medicare managed care program that, in addition to the Family Care long-term care benefits, provides managed health care benefits, and all applicable Medicare Advantage Special Needs Plan and Medicare Part D prescription drug benefits. All members enrolled in Partnership have a Wisconsin Medicaid nursing home-certifiable level of care, which is required as a condition of eligibility. As a fully integrated program, all supports and services-whether Medicare or Medicaid benefits – are delivered through the Partnership model design, which are defined in the contract.

Definitions and Requirements

Claim –

Is a single transaction submitted by a provider as a bill or other approved documents or formats for all authorized services.

Clean Claim –

A Clean Claim is a claim that can be processed without obtaining additional information from the provider of the service. A claim is still considered a clean claim if the only error(s) in the submitted information are the result of an error originating in the Department's system or with errors originating from an MCO's claims processing system problem, an MCO's internal claims or an MCO's business process problem. A clean claim does not include a claim that is under review for medical necessity or any claim from a provider who is under investigation for fraud or abuse.

Or any medical claim that is submitted with the following:

Participant's name, address, date of birth, social security number, Provider's name and identification number, address, phone number, tax identification number; dates and location of service, or ICD-10-CM description of procedures, diagnosis code (ICD-9-CM or ICD-10-CM), secondary or ICD-10-CM diagnosis code (ICD-9-CM), procedure code (CPT-4), Revenue Code, units, Days, HIPPS, and amount billed for each procedure, where applicable.

Timely Filing -

It is the policy of Community Care to only pay claim(s) submitted within the Timely Filing Provision of the Provider Contract.

Interest Payments-

According to Federal requirements, clean claims not paid within 30 days of receipt will accrue interest at the current Federal interest rate. Calculation for claims that have accrued interest is done per the guidelines set by the Prompt Payment Act and is determined by an on-line calculator.

Claim Submissions Format

A provider may submit claims via the following methods:

1. Electronic claims submission via a clearinghouse
2. If you do not have a relationship with a clearinghouse, you may submit through Office Ally. Please follow the link below for information on submission through Office Ally

http://www.communitycareinc.org/for-providers/billing-claim-submission

Claims that do meet the submission criteria are not accepted. These claims will be denied or returned to the provider for correction.

Processing Revenue Codes

Revenue Code <u>0022</u> Medicare (Family Care): *(Medicare Prime, Member receiving Skilled Care)*

An EOB/EOMB must be submitted; this indicates primary coverage. CCI will pay the primary coinsurance/copayment.

1	3a. PAT. CNTL #	123687 - 12	4. TYPE OF BILL
Medicare Claim	b. MED. REC. #	6789	213
2222 Easy Street	5. FED. TAX NO.	6. STATEMENT COVERS FROM / THRU	7
Elkhorn WI 531211104	11-1111111	07012014 / 07312014	
2623822466			

8. PATIENTS NAME	9. PATIENTS ADDRESS
b Jane Planet	a 111 North Narrow Way
	b Elkhorn c WI d 53121 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
05011925	F	070114	17	9	4		30			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
50	070814	22	073114					70	061514	063014				

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	09	1672.00	80	31.00	82	11.00
	b						
	c						
	d						

42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVER CHARGES	49
0022		RVL10	070114	31			
0120		250.00	070114	31	7500.00		
0300			070114	1	85.00		
0420			071514	2	150.00		
0250				25	190.56		
0270				2	175.02		

Revenue Code <u>0022</u> Medicare (Pace/Partnership): *(CCI Primary, Member receiving Skilled Care)*

1 Medicare Claim 2222 Easy Street Elkhorn WI 531211104 2623822466	2	3a PAT. CNTL# 123687 - 12 b. MED. REC# 6789 4 TYPE OF BILL 213
5. FED. TAX NO. 11-1111111	6. STATEMENT COVERS PERIOD FROM 06012014 THRU 06302014	7
8. PATIENTS NAME a b Jane Doe	9. PATIENTS ADDRESS a 222 North Way b Elkhorn c WI d 53125 e	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
05011925	F	06012014	17	9	4		30			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	051514	053114				

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVER CHARGES	49
0022		RVL10	060114	30			
0120		250.00	060114	30	7500 00		
0300			060114	1	85 00		
0420			061514	2	150 00		
0250				25	190 56		
0270				2	175 02		

MDS Submissions:

Minimum Data Set (MDS) must be submitted prior to RUG authorization. MDS must be submitted to CCI's Utilization Management Department. Providers must submit the MDS prior to submitting a claim.

MDS are not required for:

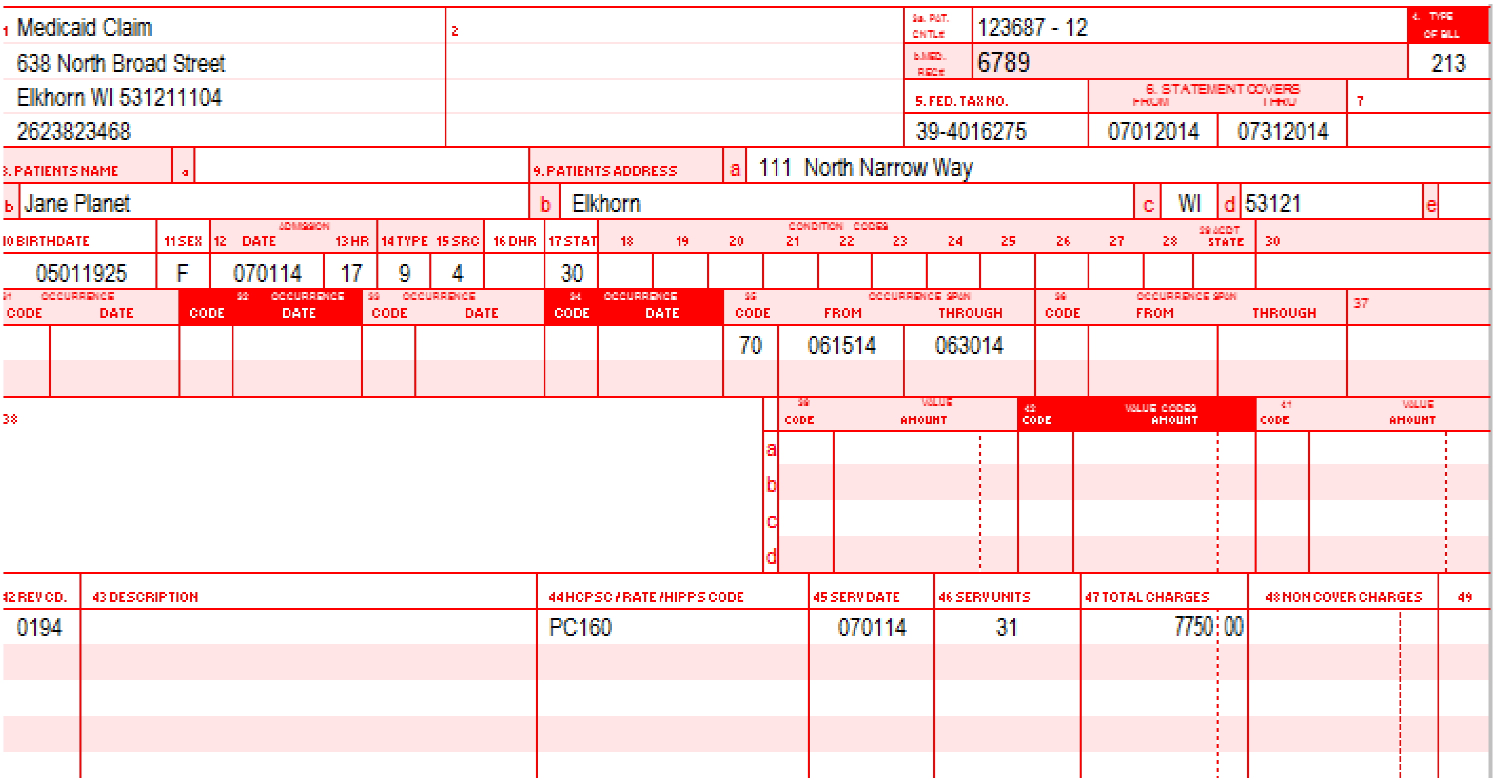
- Sub-Acute (0194) stays
- Family Care Skilled Stay (Medicare is primary)

Note: **The RUG Code and Assessment Indicator for a 0022 Stay needs to match what is authorized**

Most commonly used Medicare RUG Codes:
RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX, RUC, RUB, RUA, RVC, RBB, RHA, RMC, RMB,RMA, RLB, RLA, SE3,SE2, SE1, SSC, SSB, SSA, CCS, CC1, CB2, CB1, CAS, CA1, IB2, IB1, IA2, IA1, BB2, BB1, BA2, BB1, BA2 ,BA1, PE2, PE1, PD2, PD1, PC2, PC1, PB2 ,PB1,PA2,PA1, AAAXX

Note: This is not an all-inclusive list.

Revenue Code 0194 (Family Care, Pace/Partnership): Medicaid Payments ((*Member no longer receiving skilled care)*



1 Medicaid Claim
638 North Broad Street
Elkhorn WI 531211104
2623823468

3a. PAT. CNTL # 123687 - 12
b. MED. REC. # 6789
4. TYPE OF BILL 213
5. FED. TAX NO. 39-4016275
6. STATEMENT COVERS PERIOD FROM 07012014 THROUGH 07312014

8. PATIENTS NAME b Jane Planet
9. PATIENTS ADDRESS a 111 North Narrow Way b Elkhorn c WI d 53121

10 BIRTHDATE 05011925 | 11 SEX F | 12 ADMISSION DATE 070114 | 13 HR 17 | 14 TYPE 9 | 15 SRC 4 | 17 STAT 30

35 OCCURRENCE SPAN CODE 70 FROM 061514 THROUGH 063014

42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVER CHARGES	49
0194		PC160	070114	31	7750 00		

The HCPCS/Rates field must contain a 5-digit “HIPPS Code”. The first three positions of the code contain the RUG group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. For a complete list of AI Codes, see page 22.

Most commonly used Medicaid RUG Codes:
BA1, BA2, BB1, BB2, CA1, CA2, CB1, CB2, CC1, CC2, CD1, CD2, ES1, ES2, HB1, HB2, HC1, HC2, HD1, HD2, HE1, HE2, IB1, IB2, LA1, LA2, LB1, LB2, LC1, LC2, LD1, LD2, LE1, LE2, PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2, RAA, RAB, RAC, RAD, RAE, SE1, SE2, SE3, SSA, SSB, SSC, DD1a, DD1b, DD2, DD3

Note: This is not an all-inclusive list.

Revenue Code <u>0169</u> (Family Care, and Partnership): *(Member on Hospice)*

1	2	3a PAT. CNTL #	123687 - 12	4 TYPE OF BILL
Medicaid Claim		b. MED. REC #	6789	213
638 North Broad Street		5 FED. TAX NO.	6 STATEMENT COVERS FROM / THRU	7
Elkhorn WI 531211104		39-4016275	07012014 / 07312014	
2623823468				

8 PATIENTS NAME	9 PATIENTS ADDRESS
a	a 111 North Narrow Way
b Jane Planet	b Elkhorn; c WI; d 53121; e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
05011925	F	070114	17	9	4		30			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	061514	063014				

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV CD.	43 DESCRIPTION	44 HCPSC / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVER CHARGES	49
0169		PC160	070114	31	6626 00		

HCPCS/Rates field must contain a 5-digit “HIPPS Code”. The first three positions of the code contain the RUG group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. For a complete list of AI Codes, see page 22.

Most commonly used Medicaid RUG Codes:
BA1, BA2, BB1, BB2, CA1, CA2, CB1, CB2, CC1, CC2, CD1, CD2, ES1, ES2, HB1, HB2, HC1, HC2, HD1, HD2, HE1, HE2, IB1, IB2, LA1, LA2, LB1, LB2, LC1, LC2, LD1, LD2, LE1, LE2, PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2, RAA, RAB, RAC, RAD, RAE, SE1, SE2, SE3, SSA, SSB, SSC, DD1a, DD1b, DD2, DD3

Note: This is not an all-inclusive list.

Revenue Code 0185 (Family Care, Pace/Partnership): *(Bed-hold)*

Field	Value
1	Medicaid Claim 638 North Broad Street Elkhorn WI 531211104 2623823468
2	
3a. PAT. CNTL #	123687 - 12
b. MED. REC. #	6789
4. TYPE OF BILL	213
5. FED. TAX NO.	39-4016275
6. STATEMENT COVERS PERIOD FROM	07012014
6. STATEMENT COVERS PERIOD THRU	07312014
7	
8. PATIENTS NAME a	
8. PATIENTS NAME b	Jane Planet
9. PATIENTS ADDRESS a	111 North Narrow Way
9. PATIENTS ADDRESS b	Elkhorn
9. PATIENTS ADDRESS c	WI
9. PATIENTS ADDRESS d	53121
9. PATIENTS ADDRESS e	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
05011925	F	070114	17	9	4		30													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	061514	063014				

38		39 VALUE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODE	AMOUNT
	a						
	b						
	c						
	d						

42 REV CD.	43 DESCRIPTION	44 HCPSC / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVER CHARGES	49
0185			070114	31	6626 00		

Revenue Code <u>0946</u> (Family Care, Pace/Partnership): *(Ventilator payment rate for Medicaid))*

1 Medicaid Claim
638 North Broad Street
Elkhorn WI 531211104
5623623863

2

3a. PAT. CNTL# 123687 - 12
b. MED. REC# 6789
4. TYPE OF BILL 213
5. FED. TAX NO. 33-33333333
6. STATEMENT COVERS FROM 07012014 THRU 07312014
7

8. PATIENTS NAME a
b Jane Planet
9. PATIENTS ADDRESS a 111 North Narrow Way
b Elkhorn c WI d 53121 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
05011925	F	070114	17	9	4		30													

Columns 18–28: CONDITION CODES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	061514	063014				

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

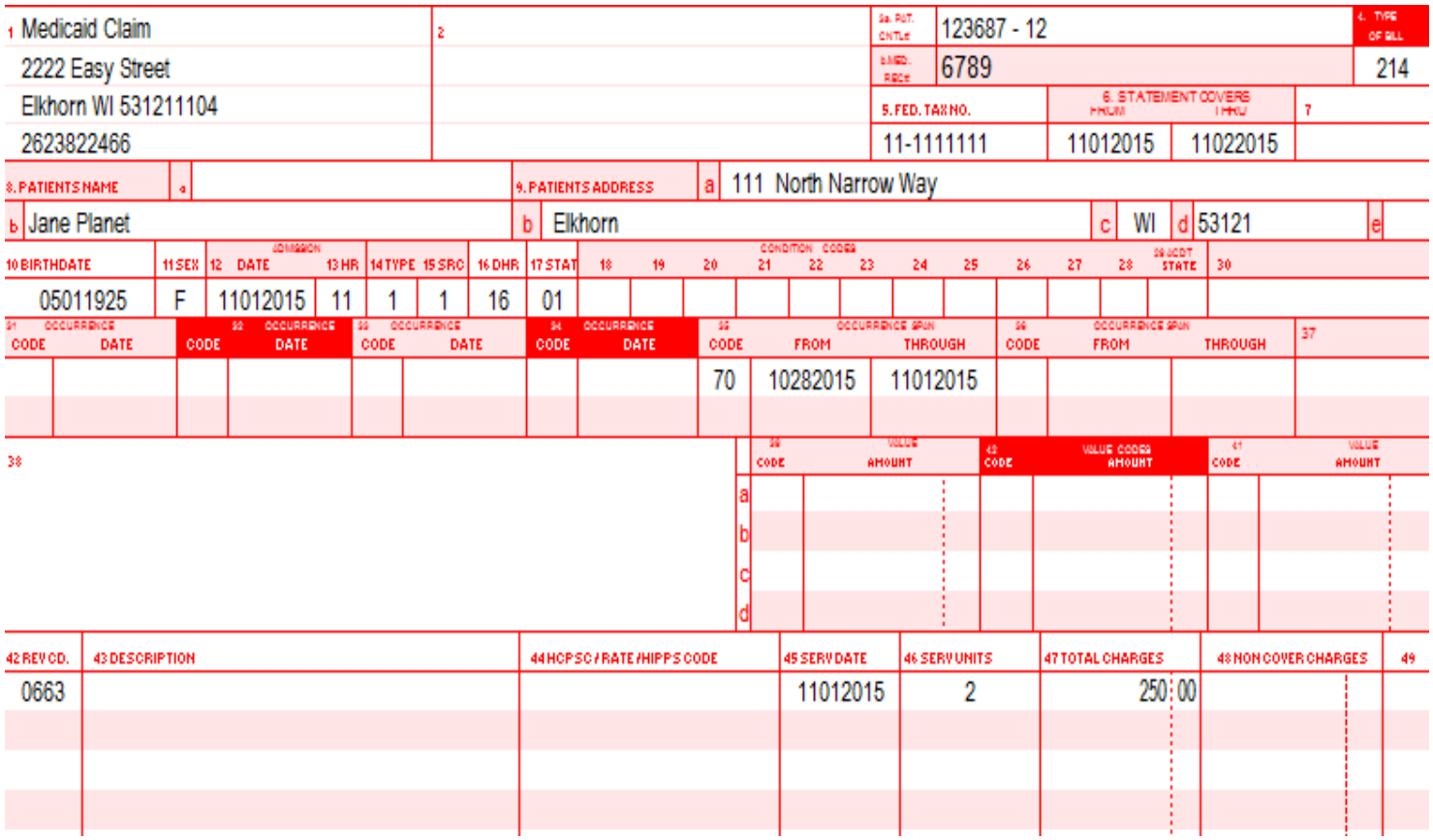
42 REV CD.	43 DESCRIPTION	44 HCPSC / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVER CHARGES	49
0946		ES360		31	4805 00		

The HCPCS/Rates field must contain a 5-digit "HIPPS Code". The first three positions of the code contain the RUG group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. For a complete list of AI Codes, see page 22.

Most commonly used Medicaid RUG Codes:
BA1, BA2, BB1, BB2, CA1, CA2, CB1, CB2, CC1, CC2, CD1, CD2, ES1, ES2, HB1, HB2, HC1, HC2, HD1, HD2, HE1, HE2, IB1, IB2, LA1, LA2, LB1, LB2, LC1, LC2, LD1, LD2, LE1, LE2, PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2, RAA, RAB, RAC, RAD, RAE, SE1, SE2, SE3, SSA, SSB, SSC, DD1a, DD1b, DD2, DD3

Note: This is not an all-inclusive list.

Revenue Code <u>0663</u> (Family Care, Pace/Partnership): *(Respite services)*



Revenue Codes 042X – Physical Therapy, 043X - Occupational Therapy and 044X – Speech Therapy:

For a Medicare Skilled Level of Care (Revenue Code 0022), therapy is included in the RUG.

For a Medicaid RUG (Revenue Code 0194), therapy is paid separately. Submit a claim with the appropriate Revenue Code and the correct CPT or HCPCS Code.

1 Medicaid Claim 638 North Broad Street Elkhorn WI 531211104 5623623863	2	3a. PAT. CNTL# 123687 - 12 b. MED. REC# 6789	4. TYPE OF BILL 223
		5. FED. TAX NO. 33-33333333	6. STATEMENT COVERS FROM 07012014 THRU 07312014

8. PATIENTS NAME	9. PATIENTS ADDRESS
a	a 111 North Narrow Way
b Jane Planet	b Elkhorn c WI d 53121 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
05011925	F	070114	17	9	4		30			

35 OCCURRENCE SPAN CODE	FROM	THROUGH
70	061514	063014

42 REV CD.	43 DESCRIPTION	44 HCPSC / RATE /HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVER CHARGES	49
0420		97110GP	07012014	1	125 00		
0420		97112GP	07012014	1	125 00		
0420		97140GP	07012014	2	250 00		
0420		G0283GP	07012014	1	125 00		
0420		G8993GPCL	07012014	1	0 01		
0420		G8994GPCJ	07052014	1	0 01		
0420		97110GP	07052014	1	125 00		
0420		97112GP	07052014	1	125 00		
0420		97140GP	07052014	1	125 00		
0420		G0283GP	07052014	1	125 00		

Therapy Coding

Therapy Discipline	Modifier	Description	Notes
OT	GO	Services delivered personally by an occupational therapist or under an outpatient OT POC (plan of care)	Modifier GO should only be indicated when submitting PA requests or claims for services rendered by a licensed occupational therapist, a certified OT assistant, or an OT student. (All relevant supervision requirements must be met for services rendered by assistants or students.)
PT	GP	Services delivered personally by a physical therapist or under an outpatient PT POC	Modifier GP should only be indicated when submitting PA requests or claims for services rendered by a licensed physical therapist, a physical therapist assistant, a PT aide, or a PT student. (All relevant supervision requirements must be met for services rendered by assistants, aides, or students.)
SLP	GN	Services delivered personally by a speech and language pathologist or under an outpatient SLP POC	Modifier GN should only be indicated when submitting PA requests or claims for services rendered by a licensed speech and language pathologist, an SLP provider assistant, or an SLP student. (All relevant supervision requirements must be met for services rendered by assistants or students.)
PT and OT	TF	Intermediate level of care	Modifier TF should be indicated when submitting claims for services provided by physical therapist assistants or certified OT assistants under general supervision. TF should not be indicated on PA (prior authorization) requests.
PT, OT, and SLP	TL	Early intervention/IFSP (Individualized Family Services Plan)	Modifier TL should be indicated when submitting claims for Birth to 3 services provided in the natural environment of a Birth to 3 members. TL should not be indicated on PA requests.

UB-04 Claim Form

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c / d / e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28 CONDITION CODES	29 ACDT STATE	30

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a		
	b		
	c		
	d		

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							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE _____ OF _____ CREATION DATE			TOTALS			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							A
B						57 OTHER PRV ID	B
C							C

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				A
B				B
C				C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A
B		B
C		C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC	
	a	
	b	
	c	
	d	

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee

LIC9213257

UB-04 Form Locator Descriptions

Required - Any data element that is needed in order to process the submission (e.g., Provider Name, NPI)
Not Required - Any data element that is optional or is not needed in order to process the submission (e.g., Patient's Marital Status) **Situational** - Any data element that must be completed if other conditions exist (e.g. if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

Field	Field Description	Field Type	Instructions
1	Provider name, Address, Telephone Number, and Country Code	Required	This field contains the complete Servicing address (the address where the services are being performed/rendered) and telephone and/or fax number
2	Pay-to Name and Address	Not Required	This field contains the address to which payment should be sent if different from the information in Field 1
3a	Patient Control Number	Required	Complete this field with the patient account number that allows for the retrieval of individual patient financial records. If completed, this number will be included on the Provider's Summary Voucher
3b	Medical/Health Record Number	Situational	In this field, report the patient's medical record number as assigned by the provider
4	Type of Bill (see Bill Type Codes page XX)	Required	This field is for reporting the type of bill for the purposes of third-party processing of the claim such as inpatient or outpatient. The first digit is a leading zero. The fourth digit defines the frequency of the bill for processional claims. The leading zero should not be reported on electronic claims
5	Federal Tax Number	Required	Enter the number assigned by the federal government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN). Affiliated subsidiaries are identified using federal tax sub-IDs
6	Statement Covers Period "From" and "Through"	Required	Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format
7	Reserved for Assignment by the NUBC	Not Used	N/A
8a	Patient Identifier	Required	This field is for the patient's identification number.
8b	Patient Name	Required	This field is for the patient's last, middle initial, and first name.
9a	Patient Address	Required	This field is for entering the patient's street address
9b	(unlabeled field)	Required	This field is for entering the patient's city
9c	(unlabeled field)	Required	This field is for entering the patient's state code
9d	(unlabeled field)	Required	This field is for entering the patient's ZIP code
9e	(unlabeled field)	Required	This field is for entering the patient's Country Code

10	Patient Birth date	Required	This field includes the patient's complete date of birth using the eight-digit format (MMDDCCYY)
11	Sex	Required	Use this field to identify the sex of the patient
12	Admission Date / Start of Care Date	Required	Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is the date care is initiated
13	Admission Hour	Not Required	Enter the hour in which the patient is admitted for inpatient or outpatient care **NOTE:** Enter using Military Standard Time (00 – 23) in top-of-the-hour times only.
14	Priority (Type) of Visit	Required	Enter the appropriate code for the priority of the admission or visit.
15	Source of Referral for Admission or Visit	Required	This field indicates the source of the referral for the visit or admission (e.g., physician, clinic, facility, transfer, etc.)
16	Discharge Hour	Not Required	This field is used for reporting the hour the patient is discharged NOTE: Enter using Military Standard Time (00 – 23) in top-of-the-hour times only
17	Patient Discharge Status	Required	Use this field to report the status of the patient upon discharge – required for institutional claims.
18-28	Condition Codes	Situational	Use these fields to report conditions or events related to the bill that may affect the processing of it.
29	Accident State	Not Required	When appropriate, assign the two-digit abbreviation of the state in which an accident occurred
30	Reserved for Assignment by the NUBC	Not Used	N/A
31-34	Occurrence Codes and Dates	Situational	The occurrence code and the date fields associated with it define a significant event associated with the bill that affects processing by the payer (e.g., accident, employment related, etc.)
35-36	Occurrence Span Codes and Dates	Required for inpatient	This field is for reporting the beginning and end dates of the specific event related to the bill.
37	Reserved for Assignment by the NUBC	Not Used	N/A
38	Responsible Party Name and Address	Not Required	This field is for reporting the name and address of the person responsible for the bill
39-41	Value Codes and Amounts	Required	These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is required by all payers
42	Revenue code	Required	Enter the applicable revenue code for the services rendered. There are 22 lines available and should include the total line for revenue code 0001

43	Revenue Description	Not Required	This field is used to report the abbreviated revenue code categories included in the bill.
44	HCPCS / Rate / HIPPS Code	Required	This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes fro specific patient groups that are the basis for payment under a prospective payment system
45	Service Date	Required	Indicates the date the outpatient service was provided and the date the bill was created using the six-digit format (MMDDYY)
46	Service Units	Required	In this field, units such as pints of blood used, miles traveled and the number of inpatient days are reported
47	Total Charges	Required	This field reports the total charges – covered and non-covered – related to the current billing period
48	Non-Covered Charges	Required	This field indicates charges that are non-covered charges by the payer as related to the revenue code
49	Reserved for Assignment by the NUBC	Not Used	N/A
50a, b, c	Payer Name	Required Situational Situational	Enter the name(s) of primary, secondary and tertiary payers as applicable. Provider should list multiple payers in priority sequence according to the priority the provider expects to receive payment from these payers.
51a, b, c	Health Plan Identification	Required Situational Situational	This field includes the identification number of the health insurance plan that covers the patient and from which payment is expected
52a, b, c	Release of Information Certification Indictor	Required	Enter the appropriate code denoting whether the provider has on file a signed statement form the member to release information. Refer to Attachment B for valid codes
53a, b, c	Assignment of Benefits Certification Indicator	Not Required	Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered
54,a,b,c	Prior Payments	Situational	Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c.
55,a,b,c	Estimated Amount Due	Not Required	Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c
56	National Provider Identifier - Billing Provider	Required	This field is for reporting the unique provider identifier assigned to the provider.

57	Other Provider Identifier -Billing Provider	Not Required	The unique provider identifier assigned by the health plan is reported in this field
58a,b,c	Insured's Name (last, first name, middle initial)	Required	The name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name and middle initial
59a,b,c	Patient's Relationship to Insured	Required	Enter the applicable code that indicates the relationship of the patient to the insured.
60a,b,c	Insured's Unique Identification	Required Situational Situational	This is the unique number the health plan assigns to the insured individual. The ID Number from the Member's Insurance Card should be entered
61a,b,c	Group Name	Situational (required if known)	Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is provided to the insured
62a,b,c	Insurance Group Number	Situational (required if known)	Enter the plan or group number for the primary, secondary and tertiary payer through which the coverage is provided to the insured
63a,b,c	Treatment Authorization Codes	Situational	Enter the authorization number assigned by the payer indicated in Field 50, if known. This indicates the treatment has been preauthorized
64a,b,c	Document Control Number	Not Required from the Provider	This number is assigned by the health plan to the bill for their internal control.
65a,b,c	Employer Name (of the Insured)	Situational	Enter the name of primary employer that provides the coverage for the insured indicated in Field 58
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	Required	This qualifier is used to indicate the version of ICD-9-CM or ICD-10-CM being used. A "9" or "0" is required in this field for the UB-04
67	Principal Diagnosis Code	Required	Enter the valid ICD-9-CM or ICD-10-CM diagnosis code (including fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered
67 a-q	Other Diagnosis Codes / Present on Admission Indicator (POA)	Situational	This field is for reporting all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment of the patient or the length of stay. The present on admission (POA) indicator applies to diagnosis codes (i.e., principal, secondary and E codes) for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting. It is the eighth digit attached to the corresponding diagnosis code
68	Reserved for Assignment by the NUBC	Not Used	N/A

69	Admitting Diagnosis	Required	Enter a valid ICD-9-CM or ICD-10-CM diagnosis code (include the fourth and fifth digits if applicable) that describes the diagnosis of the patient at the time of admission.
70 a-c	Patient's Reason for Visit	Situational	The ICD-9-CM or ICD-10-CM codes that report the reason for the patient's outpatient visit is reported here
71	Prospective Payment System (PPS) Code	Not Required	This code identifies the DRG based on the grouper software and is required only when the provider is under contract with a health plan
72	External Cause of Injury (ECI) Code	Not Required	In the case of external causes of injuries, poisonings, or adverse affects, the appropriate ICD-9-CM or ICD-10-CM diagnosis code is reported in this field
73	Reserved for Assignment by the NUBC	Not Used	N/A
74 a-e	Other Procedure Codes and Dates	Situational	This field is used to report the principal ICD-9-CM or ICD-10-CM procedure code covered by the bill and the related date
75	Reserved for Assignment by the NUBC	Not Used	N/A
76	Attending Provider Names and Identifier	Situational	This field is for reporting the name and identifier of the provider with the responsibility for the care provided on the claim
77	Operating Physician Name and Identifiers	Situational	Report the name and identification number of the physician responsible for performing surgical procedure in this field
78-79	Other Provider Names and identifiers	Situational	This field is used for reporting the names and identification numbers of individuals that correspond to the provider type category
80	Remarks Field	Situational	This field is used to report additional information necessary to process the claim
81 a-d	Code – Code Field	Situational	This field is used to report codes that overflow other fields and for externally maintained codes NUBC has approved for the institutional data set

SNF HIPPS MODIFIERS/ASSESSMENT INDICATORS

Assessment Indicators	Description
01	5-Day Medicare-required assessment/not an Admission assessment.
02	30-Day Medicare-required assessment.
03	60-Day Medicare-required assessment.
04	90-Day Medicare-required assessment.
05	Readmission/Return Medicare-required assessment.
07	14-Day Medicare-required assessment/not an Admission assessment.
08	Off-cycle Other Medicare-required assessment (OMRA).
11	5-Day (or readmission/return) Medicare-required assessment AND Admission assessment.
17	14-Day Medicare-required assessment AND Admission assessment: This code is being activated to facilitate the planned automated generation of all assessment indicator codes. Currently, code 07 is used for all 14-Day Medicare assessments, regardless of whether it is also an OBRA Admission assessment (i.e., an assessment mandated as part of the Medicare/Medicaid certification process).
18	OMRA (Other Medicare Required Assessment) replacing 5-Day Medicare-required assessment
19	Special payment situation – 5-Day assessment
28	OMRA replacing 30-Day Medicare-required assessment
29	Special payment situation – 30-Day assessment
30	Off-cycle Significant Change assessment (outside assessment window).
31	Significant Change assessment REPLACES 5-Day Medicare-required assessment.
32	Significant Change assessment (SCSA) REPLACES 30-Day Medicare-required assessment
33	Significant Change assessment REPLACES 60-Day Medicare-required assessment
34	Significant Change assessment REPLACES 90-Day Medicare-required assessment
35	Significant Change assessment REPLACES a readmission/return Medicare-required assessment.
37	Significant Change assessment REPLACES 14-Day Medicare-required assessment
38	OMRA replacing 60-Day Medicare-required assessment.
39	Special payment situation – 60-Day assessment.
40	Off-cycle Significant Correction assessment of a prior assessment (outside assessment
41	Significant Correction of a Prior assessment (SCPA) REPLACES a 5-Day Medicare-required assessment
42	Significant Correction of a Prior assessment REPLACES 30-Day Medicare-required assessment
43	Significant Correction of a Prior assessment REPLACES 60-Day Medicare-required assessment
44	Significant Correction of a Prior assessment REPLACES 90-Day Medicare-required assessment
45	Significant Correction of a Prior assessment REPLACES a readmission/return assessment.
47	Significant Correction of a Prior assessment REPLACES 14-Day Medicare-required assessment
48	OMRA replacing 90-Day Medicare required assessment.
49	Special payment situation – 90-Day assessment.
54	90-Day Medicare assessment that is also a Quarterly assessment
78	OMRA replacing 14-Day Medicare-required assessment.
79	Special payment situation – 14-Day assessment
60	Default code

UB04 Data Elements

Bill Type Codes

Note: the leading zero is ignored/not entered

Type of Bill	Description
011X -	Hospital Inpatient (Part A)
012X -	Hospital Inpatient Part B
013X -	Hospital Outpatient
014X -	Hospital Other Part B
018X -	Hospital Swing Bed
021X -	SNF Inpatient
022X -	SNF Inpatient Part B
023X -	SNF Outpatient
028X -	SNF Swing Bed
032X -	Home Health
033X -	Home Health
034X -	Home Health (Part B Only)
041X -	Religious Nonmedical Health Care Institutions
071X -	Clinical Rural Health
072X -	Clinic ESRD
073X -	Clinic – Freestanding (Effective April 1, 2010)
074X -	Clinic OPT
075X -	Clinic CORF
076X -	Community Mental Health Centers
077X -	Federally Qualified Health Centers (Effective April 1, 2010)
081X -	Nonhospital based Hospice
082X -	Hospital based Hospice
083X -	Hospital Outpatient (Ambulatory Surgery Center)
085X -	Critical Access Hospital

Patient Status Codes

Codes	Description
01 -	Discharged to Home or self care (routine discharge)
02 -	Discharged/transferred to another short-term general hospital for inpatient care
03 -	Discharged /transferred to Skilled Nursing Facility (For hospitals with an approved swing bed arrangement, use code 61 Swing Bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use code 04-ICF
04 -	Discharged/transferred to Intermediate Care Facility (ICF)
05 -	Discharged/transferred to designated Cancer Center or Children's Hospital another type of institution
06 -	Discharged/transferred to home under care of organized Home Health service organization
07 -	Left against medical advice or discontinued care
09* -	Admitted as an inpatient to this hospital
20 -	Expired (or did not cover – RNHCI)
21 -	Discharges or transfers to Court/Law Enforcement
30 -	Still Patient
40 -	Expired at Home (Hospice claims only)
41 -	Expired in a medical facility (i.e. hospital, SNF, ICF, or freestanding Hospice)
42 -	Expired – place unknown (Hospice claims only)
43 -	Discharge/transferred to federal hospital
50 -	Hospice – Home
51 -	Hospice – medical facility
61 -	Discharged/transferred within this institution to hospital based Medicare-approved Swing Bed
62 -	Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including distinct part units of a hospital
63 -	Discharged/transferred to long term care hospital
64 -	Discharged/transferred to a nursing facility certified under Medicaid but not Medicare
65 -	Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Unit of the hospital
66 -	Discharged/transferred to a critical access hospital
70 -	Discharge/transfer to another type of health care institution not defined elsewhere in the code list
71 -	Discharge/transferred/referred to another institution for outpatient services as specified by the discharge Plan of Care
72 -	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge Plan of Care

* In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier, such as observation following outpatient surgery, which results in admission.

Occurrence Codes/Dates

Codes	Description
01 -	Accident/Medical Coverage
02 -	Auto accident/no fault
03 -	Accident/tort liability
04 -	Accident/employment related
05 -	Accident/No Medical Coverage
06 -	Crime victim
09 -	Start of infertility treatment cycle
10 -	Last menstrual cycle
11 -	Onset of symptoms/illness
12 -	Date of onset for a chronically dependent individual
16 -	Date of last therapy
17 -	Date outpatient occupational therapy plan established or last reviewed
18 -	Date of retirement (patient/beneficiary)
19 -	Date of retirement (spouse)
20 -	Guarantee of payment began
21 -	UR notice received
22 -	Date active care ended
23 -	Date of cancellation of Hospice election period (FI use only)
24 -	Date insurance denied
25 -	Date benefits terminated by primary payer
27 -	Date of Hospice certification or recertification
28 -	Date comprehensive outpatient rehabilitation plan established or last reviewed
29 -	Date outpatient physical therapy plan established or last reviewed
30 -	Date outpatient speech pathology plan established or last reviewed
31 -	Date beneficiary notified intent of bill accommodations
32 -	Date beneficiary notified of intent of bill procedures or treatment
33 -	First day of Medicare coordination period for ESRD beneficiary cov by EGHP
34 -	Date of election of extended care facilities
35 -	Date treatment started for physical therapy (PT)
36 -	Date of inpatient hospital discharge for non-covered transplant patients
37 -	Date of inpatient discharge for non-covered transplant patient
38 -	Date treatment started form home IV therapy
39 -	Date discharged on a continuous course of IV therapy
40 -	Scheduled date of admission
41 -	Date of first test for preadmission testing
42 -	Date of discharge when "Through" date in Form Locator 6 (Statement Covers Period) is **not** the actual discharge date **and** the frequency code in Form Locator 4 is that of final bill
43 -	Scheduled date of canceled surgery
44 -	Date treatment started for outpatient therapy (OT)
45 -	Date treatment started for speech therapy (ST)
46 -	Date treatment started for cardiac rehabilitation
47 -	Date of cost outlier status begins

50 -	Assessment Reference Date (ARD)
A3 -	Benefits Exhausted

Occurrence Span Codes/Dates

Codes	Description
70 -	Qualifying stay dates
71 -	Hospital prior stay dates
72 -	First/Last visit
74 -	Non-covered Level of Care or Leave of Absence (LOA)
75 -	SNF level of care
76 -	Patient liability
77 -	Provider liability
78 -	SNF prior stay dates
79 -	Payer code only
M0 -	QIO/UR approved – stay dates
M1 -	Provider liability – no utilization
M2 -	Dates of inpatient respite care
M3 -	Intensive care facility (ICF) level of care
M4 -	Residential level of care

Value Codes

Codes	Description
01 -	Most common semi- private room rate
02 -	Hospital no semi-private rooms. Code requires $0.00 amount to be shown
04 -	Inpatient professional component charges which are combined billed
06 -	Medicare blood deductible
08 -	Medicare lifetime reserve first CY
09 -	Medicare coinsurance first CY
10 -	Medicare lifetime reserve second year
11 -	Coinsurance amount second year
12 -	Working Aged Recipient/Spouse with employer group health plan
13 -	ESRD Recipient/12-month coordination period w/ EGHP
14 -	Automobile, no fault or any liability insurance
15 -	Worker's Compensation including Black Lung
16 -	VA, PHS, or other Federal Agency
17 -	Operating disproportionate share amount
19 -	Operating indirect medical education amount
21 -	Catastrophic
22 -	Surplus
23 -	Recurring/monthly income
24 -	Medicaid rate code
25 -	Offset to patient payment amount – prescription drugs
26 -	Offset to patient payment amount – hearing and ear services
27 -	Offset to the patient payment amount – vision and eye services
28 -	Offset to the patient payment – amount dental services
29 -	Offset to the patient payment – amount-
30 -	Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission

31 -	Patient liability amount
32 -	Multiple patient ambulance transport
33 -	Multiple patient ambulance transport
34 -	Offset to the patient payment amount – other medical services
37 -	Pints blood furnished
38 -	Blood not replaced - deductible is patient's responsibility
39 -	Blood pints replaced
47 -	Any Liability insurance
80 -	Covered days
81 -	Non-covered days
82 -	Co-insurance days (required only for Medicare crossover claims)
83 -	Lifetime reserve days (required only for Medicare crossover claims)
A1 -	Deductible
A2 -	Co-insurance

Admission Hour

Code	Time
00 -	12:00 - 12:59 midnight
01 -	01:00 - 01:59 AM
02 -	02:00 - 02:59
03 -	03:00 - 03:59
04 -	04:00 - 04:59
05 -	05:00 - 05:59
06 -	06:00 - 06:59
07 -	07:00 - 07:59
08 -	08:00 - 08:59
09 -	09:00 - 09:59
10 -	10:00 - 10:59
11 -	11:00 - 11:59
12 -	12:00 - 12:59 noon
13 -	01:00 - 01:59 PM
14 -	02:00 - 02:59
15 -	03:00 - 03:59
16 -	04:00 - 04:59
17 -	05:00 - 05:59
18 -	06:00 - 06:59
19 -	07:00 - 07:59
20 -	08:00 - 08:59
21 -	09:00 - 09:59
22 -	10:00 - 10:59
23 -	11:00 - 11:59

Common Revenue Codes

Revenue Code	Description
0194	Nursing home admission and ongoing stay being paid with Medicaid RUG rates *(Medicaid RUG code required)*
0022 (Billed with the appropriate Room & Board Revenue Code)	Payment is expected with Medicare RUG rates (We follow Medicare guidelines, such as 3 day prior hospitalization, daily skilled services) *(Pace & Partnership Only)*
0169	As mandated by the state, this code is used when hospice services are also in place (*Medicaid RUG code required)*
0185	Bedhold reimbursement *(RUG code not required)*
0946	Ventilator payment rate for Medicaid
025X,027X, 030X,042X,043X, 044X	Various Ancillary, bill as appropriate *(not an all inclusive list)*

Troubleshooting Guide if HIPPS/RUG Codes not on EDI File

1)**.** Check with your software vendor for the exact field location on the product that HIPPS codes should be entered. Also, do they require the qualifier HP (HIPPS) to be entered as well and in what field?

2). If your software vendor confirms that the HIPPS codes are being entered appropriately have them check the output EDI file that is being submitted to the clearinghouse.

- Per the 5010 Implementation guide, this is the requirement for submitting HIPPS codes on the electronic file:

  Loop: 2400 (Institutional Service Line)
  SV2 (Institutional Service)
  SV201 (Revenue Code)
  SV202-1 (Must equal HP to signify HIPPS Code qualifier)
  SV202-2 (HIPPS code)
  SV203 (Charge)
  SV204 (Basis for Measurement Code – should be DA for days)
  SV205 (Service Unit count – Will be number of days)

  Example of the EDI output:
  SV2*0194*HP:RAE10*1765.99*DA*12~

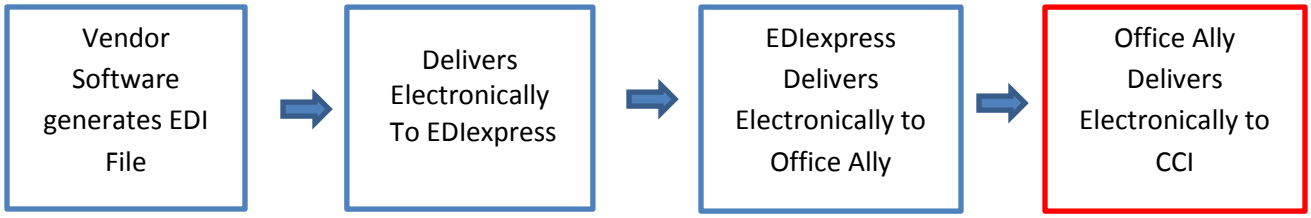
- Requirement for SNF Medicare Stay:

  Loop: 2400 (Institutional Service Line)
  SV2 (Institutional Service)
  SV201 (Revenue Code - Report Revenue Code 0022)
  SV202-1 (Must equal HP to signify HIPPS Code qualifier)
  SV202-2 (HIPPS code)
  SV203 (Charge - should be zero for revenue code 0022)
  SV204 (Basis for Measurement Code – should be DA for days)
  SV205 (Service Unit count – Will be number of days)

  Example of the EDI output:
  SV2*0022*HP:RVA30*0*DA*1~

3). If your software vendor confirms that this is on the EDI output file, request that they contact the clearinghouse that they are submitting the EDI file to. They will want to confirm that the clearinghouse is not stripping off the HIPPS code data and that the clearinghouse is forwarding it on to Community Care Inc. Note: dependent on the clearinghouse you are using, there could be more than one connection used to submit the claims to Community Care Inc. Example: Your clearinghouse is EDIexpress; EDIexpress sends the electronic claim files to Office Ally. Office Ally than submits the

electronic claims to Community Care Inc. So in this scenario, there are three different check points to ensure the HIPPS data is being sent:



Acronyms

A

AI – Assessment Indicator
ARD - Assessment Reference Date
AP – Accounts Payable
Auth - Authorization
AX – Application Extender

C

CC - Community Care
CCHP – Community Care Health Plan
CCI – Community Care Incorporated
CCO – Community Care Organization
COB – Coordination of Benefits
CFR – Code of Federal Regulations
CPT-4 – Current Procedure Terminology

D

DME – Durable Medical Equipment
DMS – Durable Medical Supplies
DOS – Dates of Service
DPU – Distinct Part Unit
DRG – Diagnosis Related Group

E

E-FORM – Electronic-Form
EFT – Electronic Funds Transfer
EGHP – Employer Group Health Plan
EIN – Employer Identification Number

EOB – Explanation of Benefits
EOMB – Explanation of Medicare Benefits
ESRD – End Stage Renal Disease

F
FC – Family Care
FI - Fiscal Intermediary

H
HCFA – Health Care Financing Administration
HCPCS – HealthCare Common Procedure Coding System
HGCF – Home Grown Claim Form
HIPPS – Health Insurance Perspective Payment System
HMO – Health Maintenance Organization

I
ICD9-CM – International Classification of Diseases – Clinical Modification
ICF – Intermediate Care Facility
ID – Identification
IRF - Inpatient Rehabilitation Facility

L
LOA – Leave of Absence
LOA – Letter of Agreement

M
MA – Medicare Advantage
MCO – Manage Care Organization
MDS – Minimal Data Set
MM – Medical Manager

N
NH - Nursing Home
NUBC – National Uniform Billing Committee
NOC – Not Otherwise Classified

O
OMRA – Other Medical Required Assessment
OSCAR – Online Survey Certification and Reporting
OSC – Occurrence Span Code
OT – Occupational Therapy

P
PACE - Program of All-inclusive Care for the Elderly
PHS – Public Health Service

POA - Place on Admission
PPS – Perspective Payment System
PT – Physical Therapy

R
RA – Remittance Advice
RNHCI – Religious Nonmedical Health Care Institution
RTP – Return to Provider
RUG – Resource Utilization Group

S
SBP – Swing Bed Provider
SNF – Skilled Nursing Facility
ST – Speech Therapy

T
TIN – Tax identification Number
TPL – Third Party Liability

U
UB – Uniform Billing
UM – Utilization Management

V
VA – Veteran's Administration

Notes

Notes