Office of Long Term Living
Provider QUICK TIPS

BILLING QUESTIONS & ANSWERS

Question	Answer
For an established resident, is the first initial PROMISe™ claim Type of Bill a 262?	No, for an established resident, the first PROMISe™ claim Type of Bill would be 263.
Do all insurances need to be reflected even if no other insurance was utilized that service month?	All third party resources that might apply should be entered even if they don't apply during the service month.
If the resident was admitted to the hospital during the prior service month, does that date carry even to the next claims admission?	Hospital stays are entered for the prior month if the hospital days are consecutive to days in the current month.
Are there claim types for adjustments and rejected claims?	Refer to the appropriate Billing Guide for Type of Bill information: UB-92-see Form Locator 4; 837 Institutional-Long Term Care-refer to loop 2300, Segment CLM (Claim Information.) When submitting claim adjustments, use a third character of 7 for Type of Bill, or an 8 when backing out a previously paid claim. For rejected claims, resubmit the claim using the same Type of Bill submitted on the original invoice.
How are adjustments paid under the old provider numbers going to be handled?	When submitting an adjustment for a claim that was paid under the MAMIS system, enter the claim reference number (CRN) from the original claim.
Is the amount of payment expected from MA supposed to be entered?	No.
Are physicians' license numbers acceptable for Provider IDs?	No. The license number is required for the Attending Physician when billing MA.
Does the admission date change if the resident is admitted to the hospital then subsequently returns to the facility? Is a new admission date (the day the resident returned from the hospital) used?	No. The only time the admission date changes is if the resident is discharged from the facility with no intention of returning but is then admitted back to the facility.
What is used for a bill classification code for a skilled admission?	The second character of the Type of Bill is the bill classification. Nursing facility services are paid based on a case mix reimbursement system, not a level of care, such as skilled or intermediate. Therefore, PA MA is using the National Uniform Billing (NUBC) Code 6 for defining nursing facility services.

Office of Long Term Living
Provider QUICK TIPS

Question	Answer
What type of bill will be used for hospital discharge?	If the resident is being transferred to a hospital with the intent of returning to the facility, the third character of the Type of Bill will be a 2 if the claim is an interim-first claim or a 3 if the claim is an interim-continuing claim. If the resident is being transferred to the hospital with no intent of returning to the facility, the third character of the Type of Bill would be a 1 if the claim is an admit through discharge or a 4 if the claim is an interim-last claim. Refer to your billing guides for additional information.
What third character for the Type of Bill will be used for admission from hospital?	If the resident is a first time admission to the nursing facility, the third character in the Type of Bill would be 1 for an admit through discharge claim or 2 for Interim-first claim.
If a resident has commercial insurance that does not cover Medicare A coinsurance days and is not otherwise involved with payment calculations for MA purposes, does that have to be listed as a resource under payer Form Locator?	All third party resources that might apply should be entered even if they don't apply during the service month.
Which admit source code is used when a resident is admitted from their home (Personal residence?)	The UB-92 Desk Reference for Long Term Care Facilities provides a list of HIPAA-compliant Source of Admission codes. Codes 1, 2 or 3 would be appropriate, depending on the referral source.
Do claims have to be submitted for months that are fully covered by other resources?	If no payment is expected from MA, it is not necessary to submit a claim for that service month. However the option to submit a "zero" bill is available.
Would there ever be two Condition Codes on the same claim?	Having two Condition Codes would be possible if the resident had two or more resources on file.
Are claims required to be submitted in sequential order?	No.
When MA is approved retroactively can claims be submitted at the same time or in sequence? Can more claims be submitted prior to payment of previous claims?	Claims may be submitted at the same time or periodically. There is no need to wait for payment of each claim before submitting the next claim.
Does the entire month have to be entered in the dates of service if some days are Medicare and some are non-covered?	Yes. The dates of service should include both full Medicare and non-covered days.
While adjusting a previously submitted claim in PROMISe™, can the claim be viewed on the screen and changes made to the claim then resubmitted?	Yes.

Question	Answer
Can the physician's 13-digit PROMISe™ provider ID be used on the 8371?	The physician's license number must be used in the 8371 transacton in the Attending Physician

Office of Long Term Living
Provider QUICK TIPS

	field.
What is the difference between Occurrence Codes A3, B3 and C3?	Occurrence Code A3 is used when primary insurance benefits are exhausted; B3 is used when secondary insurance benefits are exhausted; C3 is used when tertary benefits are exhausted. C3 is an option to use if there is a tertiary payer and beneits have been exhausted; however, it is unlikely it would be used for long term care billing purposes. For example: a resident has Medicare A, private long term care insurance and MA. Both Medicare A and private long term care insurance benefits are exhausted . Enter A3 in Form Locator 32a with the date the benefits were exhausted and enter B3 if Form Locator 33a with the date benefits were exhausted.
Are billing requirements different when submitting claims electronically vs. paper? If so, what are the differences?	The differences between paper and electronic claims submission: Paper Submission: • Admission date is required on the first claim • Medicare ICN and payment date are not required • The admission diagnosis is not required Electronic Submission: • Admission date is required • Medicare ICN and payment date are required on all claims with a condition code of X2 or X4 • Admission diagnoses must be completed

Check the Department of Human Services' Web site often: www.dhs.pa.gov
Thank you for your service to our Medical Assistance recipients.
We value your participation.