August 11, 2003

To: CBA Home and Community Support Services (HCSS) Agencies
CBA/CCAD Adult Foster Care (AFC) Providers
CBA/CCAD Assisted Living Residential Care (AL/RC) Agencies
CBA/CCAD Emergency Response Services (ERS) Agencies
CBA/CCAD Home-Delivered Meals (HDM) Agencies
CBA/CCAD Respite Care Agencies
Community Living Assistance and Support Services (CLASS) Agencies
Consolidated Waiver Program (CWP)
Consumer Managed Personal Assistant Services (CMPAS) Agencies
Day Activity and Health Services (DAHS) Agencies
Deaf-Blind with Multiple Disabilities (DB-MD) Agencies
Hospice Provider Agencies
Medically Dependent Children Program (MDCP)
Primary Home Care (PHC) Agencies
Programs of All-Inclusive Care for the Elderly (PACE) Agencies
Special Services to Persons with Disabilities (SSPD) Agencies
Nursing Facilities
Therapy Providers

Subject: Long Term Care (LTC)
Information Letter No. 03-16
Provider Letter No. 03-20
REVISED LTC Claim Form 1290 effective 10/16/2003

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is federal legislation that establishes national standards for electronic health care transactions and code sets for billing purposes. The Texas Department of Human Services (DHS) and the Texas Department of Mental Health and Mental Retardation (TDMHMR) must comply with HIPAA Electronic Data Interchange (EDI) provisions by October 16, 2003. To comply with HIPAA provisions, the billing claims format has been changed.

Who is Impacted by HIPAA?

Regardless of the method of billing used, all Long Term Care (LTC) provider agencies/facilities will be impacted by HIPAA.

Purpose of Information Letter

This information letter includes the revised LTC Claim Form 1290 (dated October 2003) and instructions on how to complete the form. The form has been revised to include changes as a result of HIPAA implementation and will become effective 10/16/03.

You are being provided with one original Form 1290. Please save the original and submit claims from a photocopied form. Should you misplace the original form, you may contact your regional contract manager for another Form 1290 or you can download the form at www.dhs.state.tx.us.

In reviewing the LTC Claim Form 1290 and instructions, you will note the following (not all-inclusive):

1) Form 1290 has been reformatted. For example, the applied income/co-pay field has been moved to the Section A Header; Nurse Aide Training has been assigned its own section.

2) New fields/terms have been added and will be required for proper billing, e.g., Rev (Revenue) Code, Modifiers, Place of Service (POS) Code, etc.

3) Some fields or terms have been deleted and are no longer required for billing, e.g., Service Group (SG).

4) In most instances, you are required to use national bill codes. For example, bill code G0701 [personal assistance services (PAS)] will be billed using the national bill code S5125.

5) The process for claims adjustment will change.

Effective Date of LTC Claim Form 1290

- For claims reviewed by NHIC **on or after** October 14, 2003, revised Form 1290 (dated 10/03) must be used.

- Claims **received** by NHIC on the Form 1290 (dated 9/99) **on or after** October 14, 2003 will be **returned** for resubmission on the revised Form 1290.

- Claims **received** by NHIC on the revised Form 1290 (dated 10/03) **on or after** October 14, 2003, will be held and processed after 10/16/2003.

- Claims **received** by NHIC on the revised Form 1290 (dated 10/03) **prior** to October 14, 2003, will be returned for resubmission on the new form after October 14, 2003.

Additional Information for using the revised LTC Claim Form 1290

- Training sessions will be provided during September for both electronic users and paper-submitter provider agencies/facilities.

- The Paper-Submitter User Manual (dated 2003) will be mailed to every provider in August. The LTC User Manual is being sent to you by the National Heritage Insurance Company (NHIC). If you do not receive the user manual by September 6, 2003, contact NHIC for a copy.

- The manual was revised to complement changes made to the Form 1290. The LTC User Manual provides detailed instructions on how to complete the form and must be used as a resource when completing the Form 1290.

- The manual provides a copy of the Bill Code Crosswalk and instructions on its use. The information from the Bill Code Crosswalk must be used when billing for services on or after October 16, 2003.

To summarize:

- All LTC provider agencies/facilities will be impacted by HIPAA changes.

- The 2003 LTC User Manual for Paper-Submitters and the revised Form 1290 (dated 10/03) become effective **October 16, 2003.**

- To learn more about how to complete the Form 1290, attend a training or workshop in August or September 2003. Please check the NHIC website for trainings/workshops in your area.

- Review the Bill Code Crosswalk to familiarize yourself with new fields that will be required by October 16.

Still have questions about this information letter?

- For community care providers, contact your regional CMS Coordinator.

- For nursing facility and therapy providers, contact the Provider Claims Services Help Desk at (512) 490-4666.

For all providers, if you have questions about general billing or the user manual, contact the NHIC LTC Help Desk at 1/800-626-4117 or 512/335-4729, in Austin.

Sincerely,

[signature on file]

Becky Beechinor
Assistant Deputy Commissioner
Long Term Care Services

BB:mgm

LONG TERM CARE CLAIM

DHS Form **1290**
October 2003

SECTION A – Header Information

1. Provider No.	2. Provider Name	3. Address		4. Telephone No.	
5. Client/Medicaid No.	6. Patient Account No.	7. Client Last Name	8. Client First Name	9. Client MI	10. Client Suffix Name

This information is for a VA client residing in a VA facility	This information is for a client requiring AI/Co-Pay
11. VA Indicator	12. Billed Applied Income / Co-Pay

THIS INFORMATION IS FOR EXPEDITED PAS USE ONLY				
13. Service Group	14. Service Code	15. Fund Code	16. Billed Amount	17. Billing Month/Year

SECTION B – Nurse Aide Training

	18. NAT SSN	19. SERVICE GROUP	20. BILL CODE	21. PATIENT DAYS %			22. BEGIN DATE (mm/dd/yyyy)	23. END DATE (mm/dd/yyyy)	24. TRAINING HOURS	25. NUMBER OF UNITS	26. UNIT RATE	27. LINE ITEM TOTAL
				MEDICAID	MEDICARE	PRIVATE						

SECTION C – Line Item Information (Note: Negative Number of Units should appear as – 00.00. Show parts of units as decimal fractions.)

Line	28. BEGIN DATE (mm/dd/yyyy)	29. END DATE (mm/dd/yyyy)	30. REV CODE	31. PROC CODE QUAL	32. PROC/ ITEM CODE	33. MODIFIERS				34. POS CODE	35. TID	36. RENDERING PROVIDER NAME	37. NUMBER OF UNITS	38. UNIT RATE	39. LINE ITEM TOTAL
						1	2	3	4						
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															
16															
17															

I certify that this information is true, accurate, and complete to the best of my knowledge. I understand that claiming for services not actually provided constitutes fraud.

41. Signature

42. Date

Claim Total: 40.

FORM 1290
Instructions

LONG TERM CARE CLAIM

10-2003

PURPOSE

For long term care providers to submit claims to National Heritage Insurance Company (NHIC) for processing in the Claims Management System (CMS).

Note: Form 1290 becomes effective October 16, 2003. Form 1290 (dated 10/03) **must** be used for claims **received** by NHIC on or after October 14, 2003.

- **Claims received on old Form 1290 (dated 9/99) on or after October 14, 2003.**

  Claims **received** by NHIC on the old Form 1290 on or after October 14, 2003, will be returned to providers for resubmission on the revised Form 1290.

- **Claims received on revised Form 1290 (dated 10/03) before October 14, 2003.**

  - Claims **received** by NHIC on the revised Form 1290 before October 14, 2003, will be returned for resubmission on the revised Form 1290.
  - Claims **received** by NHIC between October 14 and October 16 will be held and processed on October 16, 2003.

PROCEDURES

One or more claims may be submitted in one mailing. Form 1290 is used to bill for:

- new claims,
- adjustment claims,
- dental claims,
- nurse aide training (NAT) claims, and
- expedited claims.

A paper claim allows one client per claim form. A single claim form may contain up to 17 line items for that one client. Claims requiring more than 17 line items per billing must be submitted on multiple claim forms. Claims submitted on paper are sorted and imaged before being data-entered into CMS.

Process

1. NHIC receives claim form(s) requests.
2. Claims are imaged for tracking and archiving purposes.
3. Claims are keyed into CMS.
    - Attachments are not accepted as part of the claims submission process. All attachments are removed from the claim and forwarded to DHS for disposition.
    - Information is entered into CMS exactly as it appears on the claim form. No editing or corrections are performed.
4. When a claim is transmitted, CMS tests the claim for validity and acceptance requirements. The claim is paid, denied, or suspended according to the long term care (LTC) business requirements.

Paper claims are mailed to:

National Heritage Insurance Company
PO Box 200105
Austin, TX 78720-0105

Contact customer service for assistance at 1-800-626-4117.

All LTC providers are provided an original copy of Form 1290. The original should be saved and submissions made from a photocopied form. Direct questions to the provider's state contract manager.

Form Retention

Submit the original Form 1290 to NHIC. Retain a copy according to the LTC program's retention requirements.

DETAILED INSTRUCTIONS

Claims

Claims must contain the provider's complete name, address, and nine-digit provider number. A claim that does not have a provider name, address, or provider number will not be processed.

Each claim form must have an original signature.

The following instructions describe what information must be entered in each item of Form 1290. A new claim cannot be processed without the required information.

Section A — Header Information

1 – Provider No. — **This item is required except for In-Home and Family Support claims.** Enter the nine-digit number as it appears on the contract.

2 – Provider Name — **This item is required.** Enter the provider's name as it appears on the contract.

3 – Address — **This item is required.** Enter the provider's address as it appears on the contract.

4 – Telephone No. — Enter the provider's telephone number as it appears on the contract.

5 – Client/Medicaid No. — **This item is required for all claims except Nurse Aide Training (NAT) claims.** Enter the client's nine-digit client/Medicaid number.

6 – Patient Account No. — Enter the provider's internal client control number.

7 – Client Last Name — **This item is required.** Enter the client's last name. For NAT, enter the trainee's last name.

8 – Client First Name — Enter the client's first name. For NAT, enter the trainee's first name.

9 – Client MI — Enter the client's middle initial. For NAT, enter the trainee's middle initial.

10 – Client Suffix Name — Enter the client's suffix name. (**Example:** Jr., Sr.)

Note: Complete item 11 when billing for a Veteran Administrations (VA) client residing in a VA facility.

11 – VA Indicator — This item is applicable only to SGs 1 and 8. Enter "VA" if client is residing in a VA facility.

Note: Complete item 12 when billing for a client that requires Applied Income (AI)/Co-Pay.

12 – Billed Applied Income/Co-Pay — Enter the dollar amount of the client's income to be contributed to the claim or the client's assessed AI/co-pay amount.

Note: Complete items 13 through 17 for Expedited PAS Claims only.

13 – Service Group — Enter the service group.

14 – Service Code — Enter the service code.

15 – Fund Code — Enter the fund code.

16 – Billed Amount — Enter the billed amount.

17 – Billing Month/Year — Enter the two-digit month and four-digit year of the billing month/year (mm/yyyy).

Important Note:

- **Bill Code Crosswalk** — Throughout these form instructions you will be referred to the Bill Code Crosswalk. The Bill Code Crosswalk is a cross-referenced code set used to match the Texas LTC Local Codes (i.e., bill codes) to the National Standard Procedure Codes (e.g., procedure, item,

revenue codes). You must use information on the Bill Code Crosswalk (associated with the bill code that reflects the service billed) when completing Form 1290. The Bill Code Crosswalk includes codes necessary when billing for services (e.g., bill codes, Healthcare Common Procedural Coding System (HCPCS)/item codes, revenue codes, place of sale (POS) codes). The Bill Code Crosswalk is found in Appendix B of the *Long Term Care Manual for Paper Submitters*.

- **How to Use the Crosswalk** —
    1. Identify the Service Group/Service Code (SG/SC) that you are billing.
    2. Go to the Bill Code Crosswalk and find the same SG/SC.
    3. Continue on the same line. Find the corresponding information to complete the applicable items on the form. **Examples:** bill code, HCPCS/item code, revenue code, POS codes.

The Bill Code Crosswalk includes detailed procedures about using the Crosswalk.

Section B — Complete for Nurse Aide Training (NAT) ONLY

18 – NAT SSN — **This item is required.** Enter the trainee's nine-digit social security number.

19 – Service Group — **This item is required.** Enter up to five characters for the service group identification as it appears on the provider's service authorization. Refer to the Service Group column of the Bill Code Crosswalk found in Appendix B of the *Long Term Care Manual for Paper Submitters* for a list of service groups.

20 – Bill Code — **This item is required.** Enter the five-character code for the specific service provided to the client. Refer to the Bill Code column of the Bill Code Crosswalk found in Appendix B of the *Long Term Care Manual for Paper Submitters* for a list of bill codes.

Note: A procedure code qualifier is not required when billing for NAT.

21 – Patient Days % — **This item is required.** Complete one or all of the subtypes. The sum of all three types **must** equal 100.0. This percentage should consist of a maximum of three leading digits before and one digit after the decimal point. (**Example:** 100.0)

Medicaid — Enter the percentage of filled beds in the facility for Medicaid clients. This percentage should consist of a maximum of three leading digits before and one digit after the decimal point. (**Example:** 30.0)

Medicare — Enter the percentage of filled beds in the facility for Medicare clients. This percentage should consist of a maximum of three leading digits before and one digit after the decimal point. (**Example:** 30.0)

Private — Enter the percentage of filled beds in the facility for private clients. This percentage should consist of a maximum of three leading digits before and one digit after the decimal point. (**Example:** 40.0)

22 – Begin Date — **This item is required.** Enter the eight-digit begin date (mm/dd/yyyy) for the line

item (**Example:** 10/01/2003).

23 – End Date — **This item is required.** Enter the eight-digit end date (mm/dd/yyyy) for the line item (**Example:** 10/31/2003).

24 – Training Hours — **This item is required.** Enter the number of training hours completed. Include one digit after the decimal point. (**Example:** 79.5)

25 – Number of Units — **This item is required.** Enter the number of units of service provided to the client. The line item should include one digit after the decimal point. (**Example:** 139.0)

26 – Unit Rate — **This item is required.** Enter the unit rate for the service provided. The line item should include two digits after the decimal point. (**Example:** 33.00)

27 – Line Item Total — **This item is required.** Enter the line item total by calculating the information entered in items 24, 25, and 26.

Section C — Line Item Information

28 – Begin Date — **This item is required.** Enter the eight-digit begin date (mm/dd/yyyy) for the line item (**Example:** 10/01/2003).

29 – End Date — **This item is required.** Enter the eight-digit end date (mm/dd/yyyy) for the line item (**Example:** 10/31/2003).

30 – Rev Code (Revenue Code) — **This item is required for some services.** The Rev Code is used to describe a package of services provided in a 24-hour facility setting (e.g., nursing facility services or Assisted Living/Residential Care). Refer to the Revenue Code column of the Bill Code Crosswalk found in Appendix B of the *Long Term Care Manual for Paper Submitters* to determine if a Rev Code is required for the service you are billing.

Below are examples of when a Rev Code may be required.

Service	Revenue Code
Nursing Facility/Daily Care	100
Assisted Living/Residential Care	240

31 – Proc Code Qual — (Procedure Code Qualifier) **This item is required.** The Proc Code Qual describes the source of the Procedure/Item Code that you will be entering in item 32, Procedure/Item Code. There are three types of procedure code qualifiers.

1. ZZ = Texas LTC Local Codes (hereinafter referred to as Bill Code)
2. HC = Healthcare Common Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT)
3. AD = American Dental Codes

Refer to the Procedure Code Qualifier column of the Bill Code Crosswalk found in Appendix B of the *Long Term Care Manual for Paper Submitters* to determine the procedure code qualifier you will be entering when billing for a particular service.

32 – Proc/Item Code — (Procedure/Item Code) **This item is required for some services.** The Proc/Item Code describes the service provided to the client. Services provided are described by codes. There are four types of procedure/item codes.

1. Bill Codes
2. HCPCS
3. CPT
4. AD

Refer to the Bill Code, HCPCS, or CPT Codes columns of the Bill Code Crosswalk found in Appendix B of the *Long Term Care Manual for Paper Submitters* to determine the Procedure/Item Code you need to enter when billing for a particular service.

Complete this item as follows:

- If you entered the code "**ZZ**" in item 31, Proc/Item Code, enter a Bill Code.
- If you entered the code "**HC**" in item 31, Proc/Item Code, enter a HCPCS or CPT.
- If you entered the code **"AD"** in item 31, Proc/Item Code, enter a Dental Code.

33 – Modifiers — **Leave blank if this item is not applicable to the service billed.** The modifiers are used to further define a service and/or assist in determining what to pay during the claims adjudication process. Refer to Modifier columns 2, 3, and 4 of the Bill Code Crosswalk found in Appendix B of the *Long Term Care Manual for Paper Submitters* to determine if a modifier and/or more than one modifier is required when billing for a particular service.

Note about Modifiers 1 and 2: Modifiers 1 and 2, used to provide contract specific information, are not included in the Bill Code Crosswalk (e.g., service group, budget number). Use the modifier information below to determine if contract specific modifiers apply to the service billed.

Modifier 1

Complete Modifier 1 if your contract includes more than one SG. **Examples:** SG3 (CBA AL/RC) and SG7 (CCAD RC). Enter the appropriate "U" modifier (in Modifier 1 Column), from the list below. Leave blank if your contract includes only one service group.

U3 = SG 3
U7 = SG 7

Note: Hospice providers must enter a modifier (in the Modifier 1 column) to indicate if the provider is billing for an SG4, 5, or 6 MHMR client.

Modifier 2

Complete Modifier 2 if your contract requires a budget. **Examples:** PAS, ERS, Meals. Enter the appropriate "U" modifier (in Modifier 2 column) from the list below:

U1 = Budget 1
U2 = Budget 2

34 – POS (Place of Service) Code — **This item is required.** The POS Code identifies the location (e.g., nursing facility, client's home, assisted living/residential care facility, dentist office) where the service (e.g., daily care, PAS, ERS, assisted living/residential care, dental service) being billed was provided. Enter the appropriate POS code that identifies where the service was provided to the client. Refer to Appendix C, Place of Service, found in the *Long Term Care Manual for Paper Submitters* to identify the code to use when billing for a particular service.

Examples

Service	POS	POS Code
Daily Care	Nursing Facility	32
PAS/ERS	Home	12
Assisted Living/Residential Care	Assisted Living Facility	13
Dental Care	Office or Other POS	11 or 99
DAHS	Other POS	99

35 – TID (Tooth ID) — Complete this item if you are billing for services for a client receiving dental services/treatment by a licensed dentist. Enter up to a two-digit number that identifies the tooth on which the service was performed. Refer to the Tooth ID chart of the Bill Code Crosswalk found in Appendix C of the *Long Term Care Manual for Paper Submitters* to identify the tooth ID.

36 – Rendering Provider Name — **This item is required if the service (being billed) is a skilled/professional service and was provided by someone other than the provider agency (i.e., dentist, therapist, other licensed professional).** The rendering provider name identifies the name of the person that provided the service to the client. This does not apply to unskilled/nonprofessional services delivered by the provider agency (**examples:** meals, attendant services, day activity and health services).

Enter the name of the skilled/professional person, etc., that provided the service to the client. You do not need to include the person's credentials. See examples below.

Examples

Skilled/Professional Service Provided	Name of Rendering Provider
Dental Services	David Dental
Physical Therapy	Patty Therapist
Nursing Services	Nadine Service

37 – Number of Units — **This item is required.** Enter the number of units of service provided to the client. The line item should include two digits after the decimal point. (**Example:** 139.00)

Note: If the unit rate for the service you are billing is hourly, and you are billing for less than one hour of service, enter the unit in .25 increments (15 minutes).

Example: 25 hours and 30 minutes of service were provided. Enter 25.50 in the number of units field.

38 – Unit Rate — **This item is required.** Enter the unit rate for the service provided. The line item should include two digits after the decimal point. (**Example:** 33.00)

39 – Line Item Total — **This item is required.** Enter the line item total by calculating the information entered in items 37 and 38 and, if appropriate, item 12, Billed Applied Income/Co-Pay.

40 – Claim Total — Enter the claim total. The claim total is the sum of each line item.

41 – Signature — **This item is required.** Sign the form. Every claim form **must** have an original signature.

42 – Date — Enter the date the claim is submitted.

Billing for Dates of Service Before October 16, 2003

When billing for dates of service **before** October 16, 2003, **and** the claim is submitted on or after 10/16/2003, the local code (bill code) must be used. When using the local code, the "ZZ" qualifier must be used.

When billing for dates of service **on or after** October 16, 2003, the appropriate HCPCS code must be used unless the service has been identified as "Atypical."

Example of a claim submitted **on or after** 10/16/2003 (for SG 17):

Date of Service	**Service/Code**	**Bill Code/HCPCS**		**Qualifier**
09/01/2003	LVN Nursing/SC 13A	G0302		ZZ
10/18/2003	LVN Nursing/SC 13A	HC	S9124 or T1003	HC

Exceptions:

Nursing Facility/Hospice/ICF-MR

For dates of service **before** 10/16/03 **and** the claim is submitted **on or after** 10/16/03, both the revenue code and the local bill code must be used.

For dates of service **on or after** 10/16/03 **and** the claim is submitted **on or after** 10/16/03, only the revenue code should be used.

Example of a claim submitted on or after 10/16/2003 (for SG 1)

Date of Service	Service/Code	Revenue Code and Bill Code/HCPCS		Qualifier
09/01/2003	Daily Care/SC1	100	N0201	ZZ
10/18/2003	Daily Care/SC1	100		

Hospice Physician Services

Regardless of the dates of service, hospice physician services submitted on or after 10/16/03 must be billed using the revenue code and the appropriate CPT code.

Adaptive Aids/Durable Medical Equipment (DME)/Medical Supplies

Regardless of the dates of service, Adaptive Aids/DME/Medical Supplies Local Code (G0500) submitted on or after 10/16/03 must be billed using the appropriate national code.

Dental

Regardless of the dates of service, dental service claims submitted on or after 10/16/03 must be billed using the appropriate national code.

Line Item Adjustments

Line item adjustments are submitted to make a change to a previously paid claim. Line items must contain all of the original claims information exactly as shown in the R&S report. Line item information is matched to the original claim detail line item using data that includes but is not limited to service dates, codes (revenue/bill/procedure/item), and units.

The line item adjustments must contain one or more negative line items. The negative line items cancel out the applicable line items listed on the original claim that is to be adjusted. Enter the line item(s) to be adjusted as they appear on the original claim in Section B of Form 1290 except that the number of units and line item total are entered in negative amounts.

Many line items for a claim may be adjusted. Each line item adjusted must be credited back before any and all correct changes are made. The credit appears on the adjusted line item as a negative number of units on the R&S report. Not all negative line items (credited line items) have a corresponding positive line item (adjusted charge) adjustment associated with it.

Line item adjustments for dates of service **before** 10/16/03:

You must use the ZZ qualifier and the appropriate local/bill code originally used when the original claim was processed.

Line item adjustments for dates of service **after** 10/16/03:

You must use the appropriate local/national code or Revenue Code used when the original claim was processed.