Anthem BlueCross

Medi-Cal Managed Care

Provider Bulletin
December 2023

Intermediate care facility for developmentally disabled Long Term Care claims reference sheet

Thank you for your participation in the Long Term Care (LTC) Carve-In benefit for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) for 2024. This claims reference sheet provides information on billing for institutional services using the *CMS-1450 (UB-04)* form for ICF/DD, ICF/DD-H and ICF/DD-N Homes. Please note that additional information on utilizing invoices is provided on a separate reference sheet.

Anthem Blue Cross (Anthem) encourages electronic filing of claims for ICF/DD LTC room and board. Providers billing for institutional services must complete the *CMS-1450 (UB-04)* form. The form must be completed in accordance with the ***National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2023***. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Anthem's timely filing period for LTC ICF/DD claims is 180 days.

Bill types

Bill type is a four-digit number based on the NUBC data specification manual.
065 ICF/DD or ICF/DD-H
066 ICF/DD-N
The final digit is based on the following:

- 0- Non-payment/zero claim
- 1- Admit through discharge date
- 2- First interim claim
- 3- Continuing interim claim
- 4- Last interim claim
- 5- Late charge(s) only claim
- 6- First interim claim
- 7- Replacement of prior claim
- 8- Void/cancel of prior claim

ICD/DD Long Term Care services

When billing for ICF/DD LTC members, there are some key things to remember on the *UB-04* form:

- Revenue codes for ICF/DD services:

Revenue code	Description
0101	Room and board
0180	Leave of absence, general

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Share of cost/member liability

LTC ICF/DD members are responsible for paying their share of cost/member liability to the ICF/DD Home.The ICF/DD Home must indicate the member's share of cost on the *UB-04* form by using value code 23 with a $0.00 or greater dollar amount. This amount will be deducted from the amount paid to the facility.Please indicate the value code and amount in boxes 39-41 of the *UB-04* form:

- Always use the value code 23 with a $0.00 or greater dollar amount when billing all claims.
- Billing every two weeks:
  - **Example:** A member's share of cost/member liability is $1,000.
  - At the beginning of the month, use value code 23 and member's share of cost/memberliability:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	1000 00				
b						
c						
d						

Billing for the last two weeks - use the value code 23 with $0.00:

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	0 00				
b						
c						
d						

If there is no share of cost, no information is required.

Accommodation codes

Facilities must bill indicating the accommodation code that is applicable to the ICD/DD claim as this drives the appropriate payment rate for a facility based on the California long-term care Medi-Cal Managed Care (Medi-Cal) rate for the facility.

The accommodation code value must be preceded with the value code 24 in the value code field.

The following are applicable accommodation codes for ICF/DD services:

Accommodation code	Accommodation code description	Bill as a cent (Box 39-41)
41	ICF/DD 1to 59 beds	$0.41
41	ICF/DD 60 or more beds	$0.41
43	ICF/DD leave days 1 to 59 beds	$0.43
43	ICF/DD, leave days, 60 or more beds	$0.43
61	ICF/DD-H 4 to 6 beds	$0.61
62	ICF/DD-N 4 to 6 beds	$0.62
63	ICF/DD-H 4 to 6 beds, leave days	$0.63
64	ICF/DD-N 4 to 6 beds, leave days	$0.64
65	ICF/DD-H 7 to 15 beds	$0.65
66	ICF/DD-N, 7 to 15 beds	$0.66

68	ICF/DD-H, 7 to 15 beds, leave days	$0.68
69	ICF/DD-N, 7 to 15 beds, leave days	$0.69

Below are *UB-04* field descriptions and instructions:

UB-04 **field location**	**Required/optional/if application or n/a field for inpatient**	**Description and requirements**
1	Required	Rendering provider name and address - enter the provider name, address and zip code and telephone number this section
2	Required	Pay-to provider name and address - Enter the provider name, address and zip code and telephone number this section.
3a	Optional	Patient control number - This number is reflected on the *Explanation of Benefits* for reconciling payments if populated.
3b	Not required	Medical record number - Not required. this number will not be reflected on *EOB* if populated.
4	Required	Type of bill - Enter the appropriate four-character type of bill code as specified in the National Uniform Billing Committee (NUBC) *UB-04 Data Specifications Manual*: 065*;066*
5	Required	Federal tax number - Enter the Federal tax ID for the billing facility.
6	Required	Statement covers period - Enter the “From” and “Through” dates of services covered on the claim if claim is for inpatient services
7	Not required	N/A
8a	Not required	Patient name - Enter patient’s name in 8b
8b	Required	Patient name - Enter patient’s last name, first name and middle initial if known.
9	Not required	Patient address
10	Required	Patient name - Enter patient’s last name, first name and middle initial if known.
11	Required	Patient sex - Use the capital letter “M” for male, or “F” for female.
12	Required	Admission date - Enter in a six-digit format (MMDDYY), enter the date of

		admission. (Note: Should match the *from date* in line #6)
13	Required	Admission hour - Enter hour of patient's admission.
14	Required	Admission/visit type - Enter the numeric code indicating the necessity for admission to the hospital. 1 - Emergency 2 - Elective
15	If applicable	Admission source - If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. 1 - Non-healthcare facility point of origin 2 - Clinic 4 - Transfer from a hospital (different facility) 5 - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 - Transfer from another healthcare facility 7 - Emergency room 8 - Court/law enforcement 9 - Information not available B - transfer from another healthcare facility F - Transfer from hospice and is under a hospice plan of care or enrolled in a hospice program
16	If applicable	Discharge hour - Enter the discharge hour.
17	Required	Discharge hour - Enter the discharge hour.
18-28	Optional	Condition codes - Enter the Medi-Cal codes used to identify the condition relating to this bill and affect payer processing.
29	If applicable	Accident state - If visit or stay is related to an accident, enter in which state accident occurred.
30	N/A	N/A
31-34	If applicable	Occurrence Codes and Dates - Enter the codes and associated dates that define the significant even related to the claim. Occurrence codes covered by Anthem: 01 - Auto accident 02 - No fault insurance involvement - Including auto accident/other 03 - Accident/tort liability 04 -

		Employment related 05 - Other accident 06 - Crime victim
35-36	Not required	Occurrence span codes and dates
37	Not required	Internal control number/document control number
38	If applicable	Responsible party name and address - Enter the name and address of the party responsible for payment if different from name in box 50
39-41	Required	Value codes and amounts
42	Required	Revenue code – Enter the 4-digit revenue code for the services provided, for example, room and board, bed hold, leave of absence
43	Required	Revenue description - Identify the description of the particular revenue code in box 42
44	Required	Rates
45	Required	Service Date - Enter the service date in MMDDYY
46	Required	Units of service -Enter the actual number of times a single item was provided for the date of service.
47	Required	Total charges (by rev. code)
48	Not required	Non-covered charges
49	N/A	N/A
50	Required	Payer Identification (Name) - Enter “Anthem Plan Partnership Plan”
51	Not required	Health plan ID
52	Not required	Release of information certification
53	Not required	Assignment of benefit certification
54	If applicable	Prior payments - Enter any prior payments received from Other Coverage in full dollar amount
55	Not required	Estimate amount due
56	Required	NPI-Enter NPI number
57	Not required	Other provider IDs
58	N/A	N/A
59	N/A	N/A
60	Required	Insured's Medi-Cal ID - Enter the patient’s Medi-Cal ID number
61	N/A	Insured group name
62	N/A	Insured group number
63	If applicable	Treatment authorization code - Enter any authorizations numbers in this section. Member information from the authorization must match the claim.
64	Not required	Document control number

65	Not required	Employer name
66	Required	Diagnosis
67	If applicable	Principal diagnosis code/ Other diagnosis codes - Enter all letters and/or numbers of the ICD-910 CM code for the primary diagnosis including the fourth and fifth digit if present
68	If appliable	Other diagnosis codes - Enter all letters and/or numbers of the secondary ICD-9 CM code including fourth and fifth digits if present. Do not enter a decimal point when entering the code
69	If applicable	Admitting diagnosis code
70	N/A	Patient's reason for visit codes
71	N/A	PPS code
72	N/A	External cause of injury code
73	N/A	N/A
74	N/A	Principle procedure code/date
75	N/A	N/A
76	N/A	Attending name/ID qualifier 1G
77-79	N/A	Operating ID, Other ID
80	If applicable	Remarks
81 CC	Not required	Code-code field/Qualifiers

Additional information

Anthem's payer ID number: <BC001>

Submit paper claims to:

Claims and Billing
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If you have any questions about this communication, contact AnthemLiaison@anthem.com.