Intermediate Care Facilities (ICF)/Individuals with Intellectual Disabilities (IID) Billing Instructions

***Type of Bill (TOB)**: Required – Enter the appropriate 3-digit code as follows:
- 1st Digit – Type of Facility
  - 6 = Intermediate Care (LOC = ICF/MR)
- 2nd Digit – Classification
  - 5 = Intermediate Care Level - I
  - 6 = Intermediate Care Level - II
  - 7 = Intermediate Care Level - III
- 3rd Digit – Frequency
  - 1 = Admit Through Discharge Claim
  - 2 = Interim - First Claim
  - 3 = Interim – Continuing Claim
  - 4 = Interim – Final Claim
  - 7 = Adjustment/Replacement of Prior Claim
  - 8 = Void/Cancel of a Prior Claim

61X is no longer a recognized Type of Bill for ICF/IID

***Value Code**: Required – Enter the appropriate Value Code
- Covered Days is reported with Value Code 80, which must be entered in Form Locator 39-41 of the UB-04

***Revenue Code**: Required – Enter the applicable revenue code(s) which identifies the service provided. Bill a Level of Care (LOC) Revenue Code only once during the month unless the LOC changes during the month. Use the following revenue codes and descriptions:
- 183 = LOA – Home – Traditional Style Bed or ICF/IID
- 184 = LOA – Home – Home Style Facility
- 185 = LOA Hospital
- 191 = Intermediate I – Traditional Style Bed
- 192 = Intermediate II – Traditional Style Bed
- 193 = Intermediate III – Traditional Style Bed
- 194 = ICF/IID

***National Provider Identifier (NPI)** – The 10-digit NPI must be entered

***Attending Provider**: Required – The Attending provider name and the NPI cannot be the billing provider. The individual attending provider information must be entered in this field. The

Claim Example:

1 Provider Name	2			3a PAT. CNTL. # 1111		4 TYPE OF BILL
Address				b. MED REC. # 1111111111		654
City, State, Zip				5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
Telephone				00-000000	040119 / 040519	

8 PATIENT NAME	a XXXX	9 PATIENT ADDRESS	a Street Address			
b		b City		c St	d Zip	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18 19 20 21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
MMDYYYY	F	040119			01				

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
a						
b						

38	39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
	a 80 1900		
	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	193	Intermediate III - Traditional Style Bed		04012019	5				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	0001	PAGE _1_ OF _1_	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 123456789	
A ARTC	XXXXXX					57 1234567	A
B						OTHER	B
C						PRV ID	C

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A Member's Name		U00000000			A
B					B
C					C

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

66 DX F71	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 a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 1298765432	QUAL
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		LAST Doe	FIRST Jane
				77 OPERATING NPI	QUAL
				LAST	FIRST

80 REMARKS	81CC a	78 OTHER NPI	QUAL
	b	LAST	FIRST
	c	79 OTHER NPI	QUAL
	d	LAST	FIRST

UB-04 CMS-1450   APPROVED OMB NO. 0938-0997   NUBC National Uniform Billing Committee LIC9213257   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF