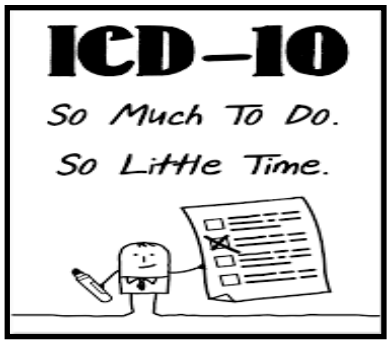


Volume 9, Issue 3

December 2015

Inside this issue:

Hawaii Medicaid Provider Bulletin

ICD-10 is Here!

Effective October 1, 2015, CMS requires that providers bill using ICD-10 codes for dates of service October 1, 2015 going forward and ICD-09 codes for dates of service prior to October 1, 2015. Xerox continues to conduct trading partner testing for ICD-10 use with providers who submit electronic claims. For more information, please contact the Xerox call center at 1-800-235-4378 and create a ticket for ICD-10 testing or email the EDI help desk at hi.ecstest@xerox.com.

For the ICD-10 implementation, this end-to end testing is used to certify provider readiness with the State of Hawaii for Hawaii Medicaid Fee-for-Service claims. All participants are encouraged to test to help ensure your preparedness before claim submission.

Please review memo FFS-1511 for ICD-10 Conversion guidelines.

ICD10 Preparedness:

- DDID Providers have received their ICD-10 diagnosis code list. Please start entering your ICD-10 diagnosis codes in your WINASAP Database. Please contact the Xerox Call Center at 1-800-235-4378 if you are missing an ICD-10 code for your existing patients. Please contact your case manager to receive the ICD-10 code for newly enrolled patients.

- Communicate and educate your staff about ICD-10. Please enforce the billing requirements advising ICD-10 is required for billing date(s) of service October 1, 2015 going forward to help prevent delays in claim payment.

MQD Division Administrator

Let's all welcome our new MQD Division Administrator Judy Mohr Peterson, PhD. She joined the Med-QUEST staff in July of this year. Welcome aboard!

WINASAP Corner!

"A successful WINASAP transmittal doesn't mean the file was accepted. After transmitting, the submitter should run the "Receive Response File" function within WINASAP. Any claims that are rejected or errored will need to be corrected and rebilled. Refer to page 242 of the WINASAP5010 User Manual for more information on this."

Please contact us via Email!

Written Correspondence can be sent via email to hi.providerrelations@xerox.com. Please encrypt your email if you are sending over sensitive information.

So many ways a claim will be Returned to a Provider (RTP)

1. Effective October 1, 2015, ICD-10 diagnosis codes should be used for "date of service" October 1, 2015 going forward and the ICD-10 indicator is now a required field
2. Missing signature
3. Always use an original printed "Red and White" Health Insurance Claim Form. Insurance companies will not accept copied claim form. Please order your medical forms through a Medical Form Supplier or order from a local supplier, Rainbow Printers, Inc. 593-9782.
4. State Identification Number for clients, Department of Safety "DPS" claims, should always have 10 digits starting with OPA, the letter "O" PA
5. Hawi ID should be 10 digits
6. Please do not use an "ink stamped" signature. Medicaid Hawaii requires a live ink signature on your CMS 1500 and on the bottom of the UB04.
7. The word "Resubmission" on your claim. If it is not a replacement claim/adjustment claim, please do not indicate the word "Resubmission", this will delay your claims process and may be subject to "RTP".
8. If you are submitting an adjustment claim, please circle changes or line out what you want to void
9. UB04 claim forms require a live ink signature. The signature may be placed near the bottom of the form in the blank area or near form locator "FL" 80 or 76
10. When attaching the EOB to your claim, please ensure it has both the dates of service of your claim and the EOB issue date listed on the EOB.

Claim Form Billing Required Updates

- Effective October 1, 2015, providers must use the new CMS 1500 claim form version 02-12. The diagnosis code indicator is now required for ICD-10 codes. The indicator field is located on FL21 on the CMS 1500 and in FL66 on the UB04. Use indicator "0" for ICD-10 codes.
- Lines cannot be added to an existing 1500 claim form. The provider may add new lines to the original claim and omit as new.
- On the CMS 1500 FL22, indicate an "A" to adjust or "V" to void when submitting an adjustment/replacement claim. On the UB04 in FL04, use bill type "xx6/xx7" to adjust or "xx8" to void the claim.

Electronic Health Records "EHR" Address Updates

Not getting your payment?

The Hawaii State Level Registry requires that you submit your 1139 for address changes. You will need the following documents to be received by Fiscal Agent, Xerox State Healthcare for faster processing: ***Live ink signature on the 1139, W9, and License attached.***

Please mail the 1139 change request form to Xerox State Healthcare with the words "EHR", written on the top of the form. For further questions in regards to the process please contact the call center at 1-800-235-4375. If you have questions in regards to the EHR program and incentive, please contact the SLR helpdesk at 1-800-235-4378 and select option 7.

A Message from the EHR Incentive Program

Want to Earn up to $63,250 in Incentive Payments? Here's how…

The American Recovery and Reinvestment Act of 2009 (ARRA) has authorized the Centers for Medicare and Medicaid Services (CMS) to provide Electronic Health Record (EHR) incentives to eligible professionals (EP) and eligible hospitals (EH) who adopt, implement, upgrade (AIU) or demonstrate meaningful use (MU) of a certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt and meaningfully use certified EHR technology.

Since the launch of the Hawaii Medicaid EHR Incentive Program in 2013, **more than $35 million in incentive payments** were made to eligible health care professionals and hospitals.

It is not too late to get started! The Hawaii Medicaid EHR Incentive Program runs until 2021; however, **2016 is the last year** a provider may begin participation in the program. Eligible professionals can participate for six years, and participation years do not have to be consecutive.

To be eligible to participate in the Hawaii Medicaid EHR Incentive Program, an EP must:

Be enrolled with the Med-QUEST Division (MQD) as a Hawaii Medicaid provider under one of these provider types:

- Certified Nurse-Midwife
- Dentist
- Doctor of Medicine
- Doctor of Osteopathic Medicine
- Optometrist
- Pediatrician (MD or DO)
- Physician Assistants (PA), who furnishes services in a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) that is so-led by a PA
- Registered Nurse Practitioner
- Have a minimum of 30 percent Medicaid patient volume, or practice predominantly in an FQHC or RHC and have at least 30 percent patient volume attributable to Needy Individuals.
- Pediatricians may qualify for reduced incentive payments with a minimum of 20 percent Medicaid patient volume.
- Have no sanctions and/or exclusions.
- Not be a hospital-based provider. A hospital-based provider is defined as a physician who provides at least 90 percent of his/her services in an inpatient hospital, outpatient hospital, or emergency department setting.
- Use a certified EHR system. A list of certified EHR systems is maintained by The Office of the National Coordinator for Health Information Technology (ONC). This may be found on the web at: http://oncchpl.force.com/ehrcert

Continue…….

A Message from the EHR Incentive Program

Eligible professionals can **receive up to $63,750** over the six years that they choose to participate in the program. The total for pediatricians who meet the 20 percent patient volume, but fall short of the 30 percent patient volume, is $14,167 in the first year, and $5,667 in subsequent years.

Participation Year	First Year Hawaii Medicaid EP Qualifies to Receive Payment			
	2013	2014	2015	2016
2013	$21,250	-	-	-
2014	$8,500	$21,250	-	-
2015	$8,500	$8,500	$21,250	-
2016	$8,500	$8,500	$8,500	$21,250
2017	$8,500	$8,500	$8,500	$8,500
2018	$8,500	$8,500	$8,500	$8,500
2019	-	$8,500	$8,500	$8,500
2020	-	-	$8,500	$8,500
2021	-	-	-	$8,500
Total Possible Incentive Payments	**$63,750**	**$63,750**	**$63,750**	**$63,750**

Learn more about the program by visiting the Hawaii Provider Outreach Page (POP) at http://hi.arraincentive.com. Here, you will also find links to the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System and the Hawaii State Level Registry (SLR).

First year participants may view an AIU attestation video guide for the Hawaii State Level Registry (SLR) at: http://www.brainshark.com/acs-inc/vu?pi=zGmzMYOMuzG0iEz0.

If you would like to start the registration and attestation process with the help of a Xerox support agent, contact the Hawaii Fiscal Agent Call Center at SLRHelpdesk@xerox.com, or (800) 235-4378 and select option #7, to schedule an appointment.

1149a Emergency Processing Denial Edits

It is patient responsibility for services not covered by emergency services. Examples of denials are "postpartum care not covered", "not eligible for payment" per 1149a and "services not emergent/does not meet criteria under emergency medical service".

1149a Appeal Process

Reasons why the patient is "not eligible for payment"

* Provider did not submit pertinent information for all dates requested
* Patient was placed in LTC level after acute stay

Who can appeal?

Hospitals may appeal the "not eligible for payment" dates by submitting medical documentation. Please contact the Xerox Call Center at 1-800-235-4378 to work with an agent who will assist you with your 1149a appeal.

Diagnosis Codes for ITOPs

1. To expedite the correct processing of ITOP claims by Hawaii Medicaid's Fiscal Agent, Xerox, an ITOP primary diagnosis must be entered in Form Locator (FL) 21.A. on the CMS 1500 claim form or FL 66 on the UB04 claim form. Please refer to Memo No. FFS-1512 http://www.med-quest.us/PDFs/Provider%20Memos/FFS-1512.pdf on the Med-QUEST website.

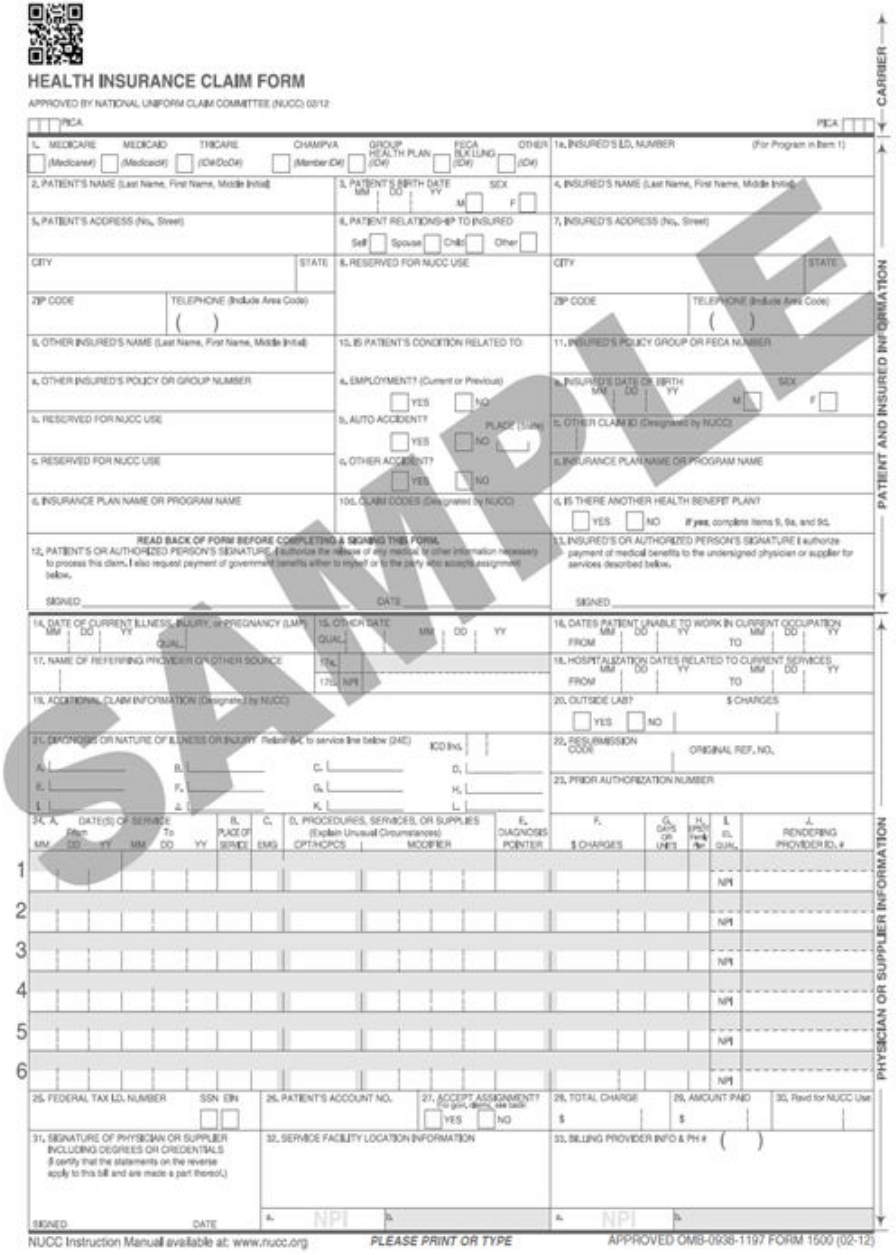
    a. For dates of service prior to October 1, 2015 claims must be submitted with ICD-9 codes in the range 635.0X to 635.9X.

    b. For dates for service on or after October 1. 2015, ITOP claims must be submitted with ICD-10 one of the ICD-10 diagnosis codes in the following table as the principal diagnosis.

2. The table below includes ICD-10 codes for dates of service on or after October 1, 2015.

ICD-10 Diagnosis	Description
Z33.2	Encounter for elective termination of pregnancy, uncomplicated
O04.5	Genital tract infection following (induced) termination of pregnancy
O04.6	Delayed or excessive hemorrhage following (induced) termination of pregnancy
O04.84	Damage to pelvic organs following (induced) termination of pregnancy
O04.82	Renal failure following (induced) termination of pregnancy
O04.83	Metabolic disorder following (induced) termination of pregnancy
O04.81	Shock following (induced) termination of pregnancy
O04.7	Embolism following (induced) termination of pregnancy
O04.85	Other venous complications following (induced) termination of pregnancy
O048.6	Cardiac arrest following (induced) termination of pregnancy
O04.87	Sepsis following (induced) termination of pregnancy
O04.88	Urinary tract infection following (induced) termination of pregnancy
O04.8	(Induced) termination of pregnancy with other and unspecified complications
O04.80	(Induced) termination of pregnancy with unspecified complications
O04.89	(Induced) termination of pregnancy with other complications
O07	Failed attempted termination of pregnancy
O07.0	Genital tract and pelvic infection following failed attempted termination of pregnancy
O07.1	Delayed or excessive hemorrhage following failed attempted termination of pregnancy
O07.2	Embolism following failed attempted termination of pregnancy
O07.3	Failed attempted termination of pregnancy with other and unspecified complications
O07.30	Failed attempted termination of pregnancy with unspecified complications
O07.31	Shock following failed attempted termination of pregnancy
O07.32	Renal failure following failed attempted termination of pregnancy
O07.33	Metabolic disorder following failed attempted termination of pregnancy
O07.34	Damage to pelvic organs following failed attempted termination of pregnancy
O07.35	Other venous complications following failed attempted termination of pregnancy
O07.36	Cardiac arrest following failed attempted termination of pregnancy
O07.37	Sepsis following failed attempted termination of pregnancy
O07.38	Urinary tract infection following failed attempted termination of pregnancy
O07.39	Failed attempted termination of pregnancy with other complications
O07.4	Failed attempted termination of pregnancy without complications

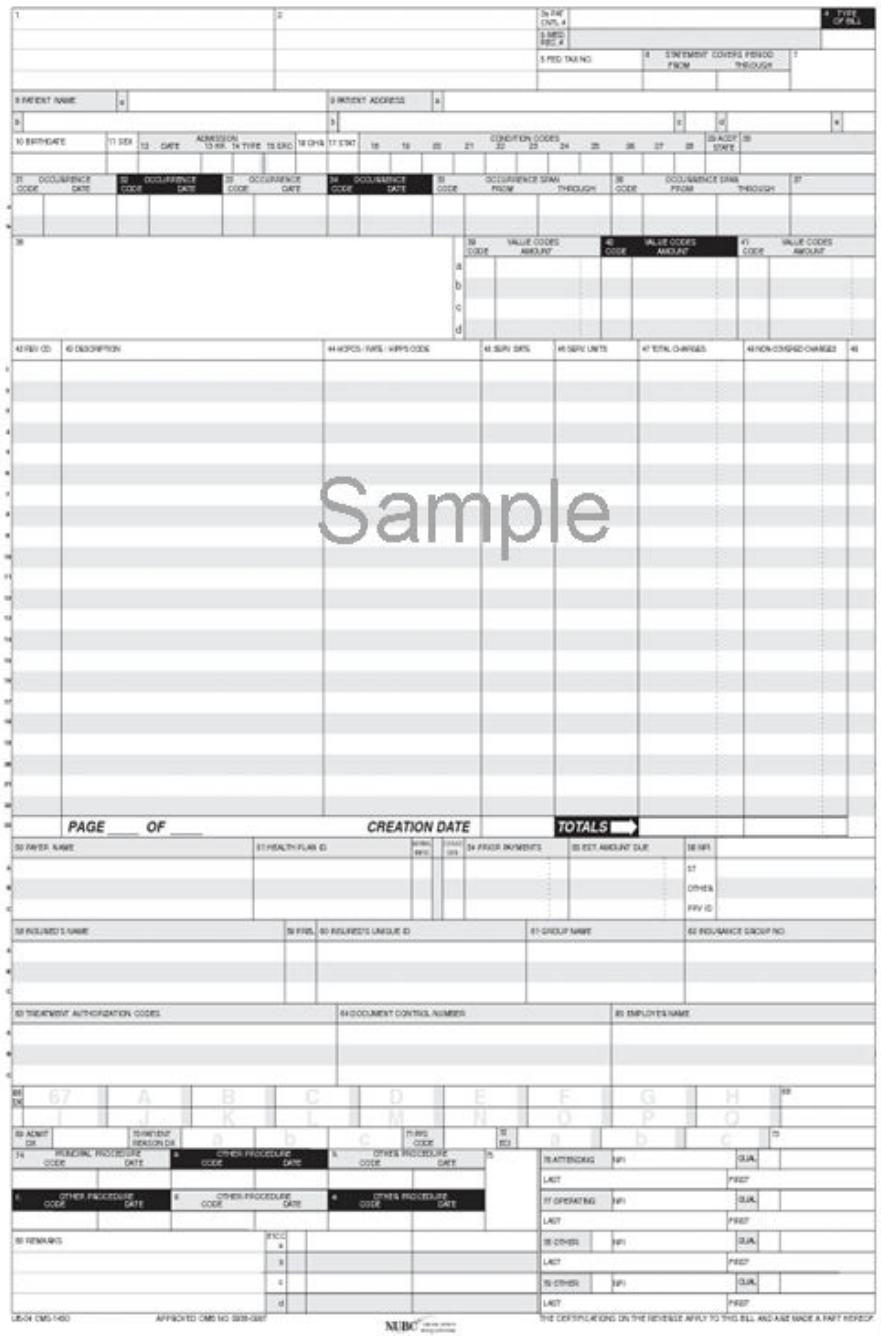
Medicaid Billing Required Fields for the CMS 1500



FL #	Field Name	Requirement	Information Required
1	Provider Name, Address, & Phone #	Required	Indicate the type of insurance coverage applicable to this claim by placing an "X" in the appropriate box. Only one box can be marked.
1a	Insured's ID Number	Required	Insured's ID number as shown on the Medicaid ID card (HAVI ID #).
2	Patient's Name	Required	Patient's full name as it appears on the Medicaid ID card.
3	Patient's Birth Date, Sex	Required	Patient's birth date (MM/DD/YYYY). Enter an "X" in the appropriate box to indicate the sex of the patient.
5	Patient's Address	Required	Patient's street, city, state, zip code, area code and phone #.
6	Patient Relationship to Insured	Required	Enter an "X" in the correct box to indicate the patient's relationship to insured.
9	Other Insured's Name	Conditional	If FL11d is marked, complete fields 9, 9a, and 9d. Otherwise leave blank. When additional health coverage exists, enter the other insured's full name if it is different from that shown if FL2.
9a	Other Insured's Policy or Group	Conditional	Policy or group number of the other insured.
9d	Insurance Plan Name or Program	Conditional	Other insured's plan or program name.
10a-c	Is Patient's Condition Related to:	Required	Indicate whether the patient's condition is a result of an employment, auto, or other type of accident.
11	Insured's Policy, Group, or FECA Number	Conditional	If the patient has another TPL, indicate the TPL policy number. If FL4 is complete, this field should be completed.
11c	Insurance Plan Name or Program	Conditional	Insurance plan or program name of the insured.
11d	Is there another Health Benefit Plan?	Conditional	Enter an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	Patient's or Authorized Person's Signature	Required	Patient's or authorized person's signature releases any medical or other information necessary to process a claim. If the signature is on file, indicate "Signature on file" and date.
14	Date of Current Illness, Injury, Pregnancy	Conditional	Enter the first date of the present illness, injury, or pregnancy (MM/DD/YY).
17	Name of Referring Provider or Other Source	Conditional	Name and credentials of the referring physician are only required for consults (99241—99275). Leave blank if not a referral.

FL #	Field Name	Requirement	Information Required
17a	Other ID #	Conditional	Medicaid qualifier "1D" and the legacy number is required when referring physician is an atypical provider.
17b	NPI#	Conditional	Enter the NPI of the referring provider.
18	Hospitalization Dates Related to Current Services	Conditional	Required for hospitalizations only. Enter the admit date followed by the discharge date. If not discharged, leave discharge date blank (MM/DD/YY).
19	Reserved for Local Use	Conditional	If it is known that the TPL does not cover a certain service, a denial does not have to be obtained, but you must indicate "Not a (name of TPL) covered service".
21	Diagnosis or Nature of Illness or Injury ICD Indicator	Required	List up to 12 diagnosis codes. For dates of service on or after 10/01/15 only ICD-10 codes will be accepted. Use the highest level of specifity possible. Do no add provider narrative in this field. Relate the appropriate diagnosis code to the lines of service in FL24E using the appropriate alpha pointer. Use "0" for ICD-10 indicator.
22	Medicaid Resubmission	Conditional	Required for resubmissions only. Enter "A" (to adjust) or "V" (to void). Also enter the original 12-digit claim reference number.
23	Prior Authorization Number	Conditional	Waiver providers must indicate a "W".
24A	Date(s) of Service [lines 1-6]	Required	Date(s) of service, from and to. If only one date of service, enter that date under "From". Leave "To" blank or re-enter "From" date. **
24B	Place of Service [lines 1-6]	Required	Enter the 2-digit place of service. **
24C	EMG [lines 1-6]	Conditional	Required for emergency services. Enter "Y" for YES or leave blank if NO. **
24D	Procedures, Services, or Supplies [lines 1-6]	Required	Enter the CPT or HCPCS code(s) and modifier (s) (if applicable) from the appropriate code set on the date of service. **
24E	Diagnosis Pointer [lines 1-6]	Required	Enter the diagnosis reference letter (pointer) as shown in FL21 to relate the date of service and the procedures performed to the primary diagnosis. **
24F	$ Charges [lines 1-6]	Required	Do not add commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number. Symbols that denote no charge for service, such as "N/C" and slashes or dashes are not a valid charges of service.
24G	Days or Units [lines 1-6]	Required	Enter the number of service units, visits or days applicable to each line. If field is left blank, the number is assumed to be 1. **
24H	EPSDT/Family Plan [lines 1-6]	Conditional	For Early & Periodic Screening, Diagnosis, and Treatment relates services. Enter a "E" only when requesting follow-ups for catch-up and preventative services. **
24I	ID Qualifier [lines 1-6]	Conditional	Enter qualifier "1D" if the provider number is the 6 or 8 digit Medicaid provider ID.
24J	Rendering Provider ID # [lines 1-6]	Required	Effective August 1, 2007 the NPI must be indicated in the un-shaded region. If an atypical provider, enter the legacy number in the shaded area.
25	Federal Tax ID Number	Required	Enter the provider of service or supplier's Federal Tax ID (employer identification number) or Social Security Number. Enter an "X" in the appropriate box to indicate which number is being reported.
26	Patient Account No.	Conditional	Enter the provider patient reference or account number.
27	Accept Assignment	Required	Enter an "X" in the correct box. Only one can be marked. Medicaid requires YES to be checked.
28	Total Charge	Required	Sum of total line charges. (I.e., total of all charges in FL24F).
29	Amount Paid	Conditional	Enter total third party amount paid.
31	Signature of Physician or Supplier	Required	Signature of Physician or Supplier Including Degrees or Credentials.
32	Service Facility Location Information	Conditional	If the service was rendered in a Facility or Hospital, or if different from billing address, enter the name and address of the facility.
32a	NPI #	Conditional	Effective August 1, 2007, enter the NPI of the service facility.
32b	Other ID #	Conditional	Enter the Medicaid qualifier "1D" followed by the Legacy number (for atypical providers).
33	Billing Provider Info & Ph #	Required	Enter the provider's or supplier's billing name, address, and phone number.
33a	NPI #	Conditional	Effective August 1, 2007, enter the NPI of the billing provider.
33b	Other ID #	Conditional	Enter the Medicaid qualifier "1D" followed by the Legacy number (for atypical providers).
NOTE			** denotes that the information must be indicated in the un-shaded section of the field.

Medicaid Billing Required Fields for the UB04



FL #	Field Name	Requirement	Information Required
1	Provider Name, Address, & Phone #	Required	Enter the provider's name, and service address and ph. #.
2	Pay-to Name, Address, and Secondary ID	Conditional	Required when the pay-to name and address information is different than the Billing Provider information in FL1.
4	Type of Bill	Required	This is a 3-digit alphanumeric code that identifies the type of facility, type of care, and the billing sequencing.
5	Federal Tax #	Required	Enter the Provider's Tax ID#.
6	Statement Covers Period	Required	From and through dates for this billing period. (MM/DD/YY).
8b	Patient Name	Required	Medicaid Recipient's last name, first name and middle initial as it appears on their Medicaid ID card.
9	Patient Address	Required	Patient's street number and name of post office box, city, state and zip code.
10	Patient Birth Date	Required	Month, day and year of the recipient's birthday (MM/DD/YYY). This information must correspond with the birthday on the Medicaid ID card.
11	Patient Sex	Required	Enter "M" for male, "F" for female.
12	Admission Date	Conditional	Required if patient was admitted (01-24 hrs.).
13	Admission Hour	Conditional	Required if patient was admitted. (01-24 hrs.).
14	Type of Admission / Visit	Conditional	Required if patient was admitted. Enter the admission type code.
16	Discharge Hour	Conditional	Discharge hour is required if patient is discharged on end date of service. This field must be left blank if no discharge hour applies. "00" is not a valid entry (01-24 hrs.).
17	Patient Status	Conditional	Required if the patient was admitted. Enter patient status code.
18-28	Condition Codes	Conditional	Required if the patient was admitted. Enter patient condition code.

FL #	Field Name	Requirement	Information Required
31-34	Occurrence Code/Date	Conditional	If occurrence code is billed, a corresponding date must be billed (MM/DD/YY).
35-36	Occurrence Span Code/Date	Conditional	If occurrence code is billed, occurrence span date (both from and to date) is required (MM/DD/YY).
39-40	Value Codes	Conditional	When Medicare is the TPL, coinsurance/deductible amount must be indicated along with the corresponding value code.
42	Revenue Code	Required	Enter the appropriate 4-digit revenue codes to identify specific accommodation and / or ancillary charges.
44	HCPCS/Rates	Conditional	Required for outpatient services (except for outpatient rev. codes 025x or 063x). Enter the HCPCS code for all services.
45	Created Date (line 23)	Required	Date of signature (MM/DD/YY).
46	Units of Service	Required	Required when billing with revenue codes.
47	Total Charges	Required	Sum charges. You will no longer be required to use revenue code 0001 to sum charges.
48	Non-covered Charges	Conditional	Non-covered charges must be indicated here.
50A-C	Payer Name	Required	Enter the names of the appropriate payers listed in order of primacy (primary payer on Line A, secondary on line B and tertiary on line C). Indicate "Medicaid" as the payer on the appropriate line.
54	Prior Payments	Conditional	Required when TPL applies. Enter the total amount paid by TPL on every line. If no payment was made, enter "0".
56	NPI	Required	10-digit NPI
58	Insured's Name	Conditional	On the same lettered line (A,B, or C) that corresponds to the line on which Medicaid payor information is shown in FLs 50-54, enter the patient's name as shown on the Medicaid ID card.

FL #	Field Name	Requirement	Information Required
59	Patient's Relationship to	Conditional	If occurrence code is billed, a corresponding date must be billed (MM/DD/YY).
60	Insured's Unique ID	Required	On the same lettered line (A, B, or C) that corresponds to the line on which Medicaid Payor information is shown in FLs 50-54, enter the patient's 10-digit HAWI ID.
61	Insurance Group Name	Conditional	Indicate the insurance group name that coordinates with the insured indicated in FL58 A-C.
62	Insurance Group #	Conditional	Enter the ID#, control # or code assigned by the appropriate insurance carrier that corresponds to group FL61 A-C.
64	Document Control #	Conditional	Required for resubmission. The original 12-digit claim reference number must be indicated in FL64 A.
66	Diagnosis Code Indicator	Required	For dates of service 10/01/2015 going forward please enter "0" for ICD-10 CM diagnosis code.
67	Principal Diagnosis Code	Required	Enter the Principal Diagnosis Code.
67A-Q	Other Diagnosis Codes	Conditional	Hawaii Medicaid allows for the entry of up to 10 diagnosis codes. Provider may not duplicate the principal diagnosis listed in FL67.
69	Admitting Diagnosis Code	Conditional	Required if the patient was admitted.
74	Principal Procedure Code & date	Conditional	Required on inpatient claims when a procedure was performed. Not used on outpatient claims.
76	Attending– NPI/Qual/ID	Required	Required when the claim contains any services other than non-scheduled transportation services.
80	Remarks	Conditional	Enter remarks needed to provider information that is not shown elsewhere on the bill but which is necessary for proper payment.)I.e. "Not a three day qualifying stay" or "Not a TPL/ Medicare covered benefit").

Allowable Bill Types for Intermediate Care Facility (ICF) and Sub-Acute Services

The Department of Human Services, Med-QUEST Division (MQD) is issuing this memorandum to update the allowable bill type codes for covered Hawaii Medicaid long-term care (LTC) facility services. This memorandum replaces (ADM-1319, ADMX-1318, and FFS M15-01. This memorandum applies to claims submitted to QUEST Integration health plans and to Fee-for-service (FFS) Medicaid. In Managed care, for dates of service October 1, 2015 or later, use the allowable types of bill and qualifying conditions below. Please refer to memo FFS-1509 http://www.med-quest.us/PDFs/Provider%20Memos/QI-1514_FFS-1509.pdf on the Med-QUEST website.

Type of Bill	Service Provider	LTC Services	Qualifying Conditions
11x	Acute Care Hospitals	Acute waitlisted ICF and SNF (skilled nursing facility) room & board	1147 authorization; use value code 74 for ICF and 75 for SNF
21x	LTC facilities	SNF room & board	1147 authorization
21x	Acute Care Hospitals and LTC facilities	Acute waitlisted sub-acute and sub-acute care room & board	1147 authorization; must be billed with revenue codes 0191 (subacute level 1) or 0192 (subacute level 2)
28x	Critical Access Hospital Swing Bed	ICF and SNF room & board	1147 authorization for SNF or ICF services
66x	LTC facilities	ICF services (room & board)	1150 authorization
65x	ICF-ID (Intellectual Disability) facilities	ICF-ID services (room & board)	1150 authorization
22x	Acute Care Hospitals and LTC facilities	SNF and ICF ancillaries that are submitted to QI health plans when Medicare is primary. Room & board services are submitted on separate claim.	1147 authorization for SNF services; no ancillaries are payable for sub-acute levels of care.
23x	Acute Care Hospitals and LTC faculties	ICF and SNF ancillaries that are submitted to QI health plans when Medicaid is primary. Room a& board services are submitted on separate claim.	1147 authorization for SNF or ICF services; no ancillaries are payable for sub-acute levels of care
22x	Critical Access Hospital Swing Bed	ICF and SNF ancillaries that are submitted to QI health plans when Medicare primary. Room & board services are submitted on separate claim.	1147 authorization for SNF or ICF services; no ancillaries are payable for sub-acute levels of care
23x	Critical Access Hospital Swing Bed	ICF and SNF ancillaries that are submitted to QI health plans when Medicaid primary. Room & board services are submitted on separate claim.	1147 authorization for SNF or ICF services; no ancillaries are payable for sub-acute levels of care