

Skilled Home Health Information Session

May 20, 2026

Neighborhood D-SNP Plans

INTEGRITY for Duals (HMO D-SNP)

A fully integrated dual special needs plan (FIDE-SNP) that integrates ALL covered **Medicare and Medicaid** managed care benefits into one plan.

- ❑ Members enrolled in Neighborhood INTEGRITY for Duals have their Medicare and Medicaid claims processed by Neighborhood without the provider resubmit the claim for Medicaid payment.

Dual CONNECT (HMO D-SNP)

A coordination-only dual special needs plan (CO D-SNP) where only **partial dual eligible individuals** who participate in the Rhode Island Medicare Premium Payment Program are eligible.

- ❑ Neighborhood manages the Medicare portion, while providers must submit copays/coinsurance amounts and **Medicaid only** benefits to the RI EOHHS for reimbursement. **Providers can not bill members for cost-share.**

Claims Submission



- All claims **must be filed electronically** except claims with any type of attachment including, but not limited to the following, which must be submitted in paper form:
 - Medical records
 - Single case agreements
- Complete claims must be received within 180 days from the date of service unless otherwise specified in the provider's contract.
- For dates of service on and after January 1, 2026, home health providers must bill Neighborhood in the same manner they bill Medicare and submit claims on an **institutional claim form. Claims submitted on a 1500 professional claim form will not pay.**

Electronic claims payer ID number for all lines of business (effective 1/1/26):

05047

Paper claims can be mailed to:

Neighborhood Health Plan
of Rhode Island
P.O. Box 28259
Providence, RI 02908-3700

Note: All coordination of benefit (COB) claims, also known as secondary claims, must be submitted electronically.

Skilled Home Health Requirements



At a minimum, providers must ensure claims are submitted in accordance with the applicable requirements in the [Medicare Claims Processing Manual](#).

UB-04 Field	Form Locator Name	Valid Data
FL6	Statement Covers	The Statement Covers Period “Through” date for continuous care periods Statement must be 29 days after the Statement “From” date for a 30-day period of care.
FL12	Admission Date	Admission/Start of Care Date is to be the first period of care in the admission. Subsequent periods continue to be the admission date reported on the first period of care.
FL17	Discharge Status	Discharge Status is to be the NUBC code that accurately describes the patient’s status as of the “through” date of the billing period.
FL18-28	Condition Code(s)	Condition Code(s) are NUBC approved codes that describe conditions that apply to the claim.
FL31-36	Occurrence Code(s)	Occurrence code(s) <ul style="list-style-type: none"> • See Appendix in Reference Guide for Condition Code(s) and usage definition.
FL39-41	Value Code(s)	Value Code(s) <ul style="list-style-type: none"> • See Appendix in Reference Guide for Value Codes and usage definition.

Skilled Home Health Requirements



UB-04 Field	Form Locator Name	Valid Data
FL42	Revenue Code	<ul style="list-style-type: none"> • HH PPS must report a revenue code of 0023 which contains HIPPS code. <ul style="list-style-type: none"> • For initial periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the period. • For subsequent periods, the HHA reports on the 0023 revenue code the date of the first visit provided during the period, regardless of whether the visit was covered or noncovered. • See the Skilled Home Health Billing Reference Guide for additional revenue code requirements, including applicable 027X, 042X, 043X, 044X, 055X, 056X and 057X revenue codes and related HCPCS code guidance
FL44	HIPPS Code	<ul style="list-style-type: none"> • The Outcome and Assessment Information Set (OASIS)

[Neighborhood Skilled Home Health Billing Reference Guide](#)

Common Billing Errors



	Billing Error	Results In...	How to Avoid
1	Absence of HIPPS REV Code 0023, - claim line data element	Claim will deny	Include Code 0023 for skilled home care
2	Billing single days for skilled home care – claim header data element	Claim will deny	Statement coverage period must be episodic (30 days)
3	Missing condition codes - claim header data element	Claim will deny	Include condition codes
4	Missing value codes - claim header data element	Claim will deny	Include value codes
5	Missing site of service procedure code – claim line data element	Claim will deny	Include site of service
6	Incorrect type of bill used for Medicare billing	Claim will not process correctly.	Re-submit on institutional (UB-04) claim form
7	Using wrong member ID	Claim will not process correctly	Use the member’s INTEGRITY for Duals ID which begins with “12”

Claim Denials

If you have submitted a claim that did not pay:

- If the original claim rejected, submit a **new claim** with the required billing elements on an institutional claim form.
- If the original services were submitted on a 1500 professional claim form, submit a **new claim** with the required billing elements on an institutional claim form.
- If the original services were already submitted on an institutional claim form, submit a **corrected claim** with the required billing elements.

Remittance Advice

Line #	Date of Service	Procedure Code	Mod (s)	Units	Charged Amount	Allowed Amount	Denied Amount	Deduct. Amount	Copay /Coins	OI Allowed	OI Paid	Payment	CP	EX Code
1	01/05/26-01/05/26	71046		1.00	125.00	33.97	0.00	0.00	0.00/6.79	0.00	0.00	26.64	N	27 Sequestration 1185
1	01/05/26-01/05/26	71046		1.00	125.00	0.00	0.00	0.00	0.00/0.00	17.75	0.00	0.00	N	172 3032 1185
Interest Paid												0.00		
Withholds												0.00		
Claim Totals					125.00	33.97	0.00	0.00	0.00/6.79	17.75	0.00	26.64		

Understanding the Medicare Payment (Row 1)

For the Medicare portion of the claim:

1. The Medicare allowed amount is determined
2. Member Cost share is applied
3. A 2% sequestration reduction is applied to the remaining balance
4. The final result is the payment amount shown on the ERA

Remittance Advice

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Interest Paid												0.00		
Withholds												0.00		
Claim Totals					125.00	33.97	0.00	0.00	0.00/6.79	17.75	0.00	26.64		

Why Coinsurance Appears on the ERA

When a service is covered by both Medicare and Medicaid:

- **The first row of each claim line** of the ERA reflects the **Medicare** adjudication outcome of the claim.
 - Medicare may apply a patient cost share amount (i.e. deductible/copayment/coinsurance)
- **The second row of each claim line** reflects the **Medicaid** adjudication outcome of the claim.
 - Medicaid processing eliminates the patient responsibility

Remittance Advice

Line #	Date of Service	Procedure Code	Mod (s)	Units	Charged Amount	Allowed Amount	Denied Amount	Deduct. Amount	Copay /Coins	OI Allowed	OI Paid	Payment	CP	EX Code
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Medicare/Medicaid Crossover

The Medicaid program will pay the lesser of:

- The difference between the Medicaid program allowed amount and the Medicare payment (Medicaid program allowed minus Medicare paid); or
- The Medicare coinsurance and deductible up to the Medicaid program allowed amount

When the Medicare reimbursement is greater than the Medicaid allowance, no reimbursement is issued as the service is considered paid in full by the primary payor, in this instance Medicare.

Billing Members

Other than allowable co-payments or deductibles for certain lines of business, **in no event can the provider bill, balance bill or have any recourse against Neighborhood members** for services rendered by the provider under their agreement with Neighborhood.

Note: Neighborhood Dual CONNECT members cannot be billed any cost-share due to Qualified Medicare Beneficiary (QMB) status.

Providers may NOT bill members for missed appointments.

Deemed Eligibility

- A temporary period where members continue to receive Medicare Advantage benefits after losing Medicaid eligibility.

- ❖ INTEGRITY for Duals (90 days)
- ❖ Dual CONNECT (30 days)

- Medicaid benefits, cost-sharing and premium coverage may be paused during this time. Members may be responsible for out-of-pocket costs or increased cost-sharing for Medicare covered services.
- Neighborhood works with members to restore Medicaid eligibility and adjusts claims once it's reinstated.

Resources



General

- [Provider Manual](#)
- [Quick Reference Guide](#)
- [Claims and Eligibility Information](#)
- [Claim Adjustments](#)
- [Navinet \(claim status, member eligibility\)](#)
- [Provider Resources](#)

Home Health Care Specific

- [Skilled Home Health Billing Reference Guide](#)
- [Medicare Claims Processing Manual](#)
- [Home Care Discharge Communication E-Form](#)
- [LTSS Application Assistance Referral Form](#)
- [Reference Guide for Private Duty Nursing \(PDN\) Requests](#)
- [Prior Authorization Requests for Skilled Home Healthcare Services Desktop Reference Guide](#)
- [Home Health Agency Services Payment Policy](#)
- [Home Care Clinical Medical Policy](#)
- [Home Care Services Prior Authorization Request Form](#)

Questions?



Please contact **Provider Services** at (800) 963-1001 for questions regarding any of the below topics:

- Contract rates
- Member eligibility issues
- Claim status/issues
- Specific payment policy questions
- General prior authorization inquiries
- Member Benefit questions

If your patients have any concerns, please have them contact Member Services at

1-866-696-4774

Neighborhood is contracted with [NaviNet](#) to provide online eligibility and claims status lookup 24/7.