MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Home Health Agencies 03-09
Private Duty Nursing Agencies
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Issued: October 15, 2003

Subject: Clarification of Correction to New Institutional Billing and Reimbursement Chapter IV

Effective: October 1, 2003

Programs Affected: Medicaid, Children's Special Health Care Services

Michigan Medicaid has announced activation of it's contingency plan in regard to HIPAA compliance on transactions and code sets for Medicaid providers. For more information, refer to numbered letter L 03-26.

This bulletin replaces bulletin MSA 03-17 (issued October 1, 2003), and is intended to provide clarity and updated billing instructions to those contained in the new Institutional Billing and Reimbursement Chapter IV effective October 1, 2003.

Date of Service Versus Date of Submission

When preparing claims, providers must always utilize the revenue and/or procedure code(s) in effect on the **date the service was provided**. For **all other code sets** required to complete a claim (e.g. condition codes, occurrence codes, value codes, etc.), providers must use the codes in effect on the **date the claim is submitted**.

Specific Coding Clarifications

- Outpatient Hospitals – Children's Multidisciplinary Specialty (CMS) clinics (bulletin Hospital 03-10)
  - Dates of service **prior to October 1, 2003** - use Revenue Code 0519 and CMS Clinic codes MS002 – MS050.
  - Dates of service **on or after October 1, 2003 -** use the appropriate Clinic Visit Revenue Code in Chapter IV, Section 5, Page 14 (the Institutional Billing and Reimbursement Chapter).

- Outpatient Hospitals – Diabetic Self Management Education (bulletin Hospital 03-10)
  - Dates of service **prior to October 1, 2003** – use Revenue Code 0942.
  - Dates of service **on or after October 1, 2003 –** use Revenue Code 0942 and the HCPCS codes in Chapter IV, Section 5, Page 15 (the Institutional Billing and Reimbursement Chapter).

- Hospices – LTC Room and Board (bulletin Hospice 03-01)
  - Dates of service **prior to October 1, 2003 -** use Revenue Code 0659.
  - Dates of service **on or after October 1, 2003 –** use Revenue Code 0658 in Chapter IV, Section 9, Page 1 (the Institutional Billing and Reimbursement Chapter).

- Private Duty Nursing Agencies – HCPCS Codes (bulletin MSA 03-11)
  - Dates of service **prior to October 1, 2003 -** use Revenue Code 0582 and the supporting HCPCS codes.
  - Dates of service **on or after October 1, 2003 –** use Revenue Code 0582 and the HCPCS codes in Chapter IV, Section 8, Page 2 (the Institutional Billing and Reimbursement Chapter).

Offset to Patient-Pay Amount for Non-Covered Services – Billing Instructions
The following information, previously transmitted in bulletin MSA 03-17, has not changed.

As of October 1, 2003, Medicaid All Provider Bulletin 03-09 stated that Medicaid would no longer cover chiropractic, podiatry, hearing aid dealer, and dental (other than emergency dental or oral surgery) services for beneficiaries age 21 or older. The Medicare Catastrophic Act of 1988 allows nursing facility beneficiaries to access their patient-pay amount to pay for necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program.

Nursing Facilities

All Provider Bulletin 03-09 stated that Medicaid would provide billing information regarding offsets to the patient-pay amount. This bulletin contains those instructions. These instructions are for dates of service on or after October 1, 2003.

Hospice Agencies

Because offset to the patient-pay amount affects hospice agencies that are providing services to beneficiaries residing in a nursing facility, this bulletin contains the billing instructions for the hospice. These instructions are for dates of service on or after October 1, 2003.

Hospice agencies are reminded that if a hospice beneficiary is in a nursing facility, it is the hospice's responsibility to collect the patient–pay amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

Prior Approval

All Provider Bulletin 03-09 and Nursing Facility Bulletin 02-02 stated that prior approval must be obtained from Medicaid to offset the patient-pay amount. *This requirement has been lifted.* The nursing facility or hospice do not need to obtain prior authorization to offset the patient-pay amount.

Appointment with Ancillary Provider/Fiscal Record

The beneficiary or beneficiary's representative may choose to purchase non-covered services directly from an ancillary provider. The beneficiary pays the ancillary provider directly for the services provided.

The nursing facility and hospice agency must retain, in the beneficiary's fiscal record, receipts showing that the beneficiary paid for the particular non-covered service. Medicaid post-payment reviews will be conducted to assure that the beneficiary's fiscal record contains the receipts.

Billing Instructions

Claims containing an offset to the patient-pay amount cannot be split-billed. The facility and hospice must submit one claim for the particular month of service.

The offset for the non-covered service must be reported on the claim using the appropriate Value Code in F.L. 39 and the related dollar amount. New Value Codes were approved by the National Uniform Billing Committee (NUBC) on September 17, 2003 and are available on the NUBC website www.nubc.org. Only value codes for Michigan Medicaid non-covered services will be activated for approval through the claims processing system.

The dollar amount of Value Code D3 - Estimated Responsibility Patient (Patient-Pay Amount) is the beneficiary's monthly patient-pay amount MINUS the dollar amount of the offset.

The total of D3 and the offset must equal the beneficiary's patient–pay amount for that given month.

Offsetting the patient-pay amount may involve more than one month. For example, the beneficiary may have a patient-pay amount of $200 per month. The amount to be offset is $500. The amount to be offset would involve a three-month period. The first month claim would indicate $200 as an offset with D3 as zero. The second month claim would show $200 as an offset with D3 as zero. The third month claim would show $100 as an offset with D3 as $100.

Manual Maintenance

The above information will be incorporated in the Medicaid Manual in the near future. Until the information is added, providers are to retain this bulletin.

Bulletin MSA 03-17 is obsolete and should be discarded.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail Providersupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration