

Michigan Department of Community Health

Bulletin Number: MSA 12-01

Distribution: Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, Hospital Swing Beds, and Ventilator Dependent Care Units

Issued: January 19, 2012

Subject: Reporting Medicare on the Medicaid Nursing Facility Claim

Effective: February 17, 2012

Programs Affected: Medicaid

THIS BULLETIN MUST BE SHARED WITH THE FACILITY'S ADMINISTRATOR AND BILLING DEPARTMENT. THIS BULLETIN DISCUSSES THE REPORTING OF MEDICARE COVERAGE ON THE MEDICAID NURSING FACILITY CLAIM.

When billing Medicaid for beneficiaries who have Medicare, the appropriate Medicare information must be reported on the claim. The Medical Services Administration has improved its claims processing logic by aligning the Community Health Automated Medicaid Processing System (CHAMPS) with the National Uniform Billing Committee (NUBC) and the Michigan Department of Community Health (MDCH) Electronic Submission Manual, including Companion Guides.

MEDICAID IS ONLY CONSIDERED THE PRIMARY PAYER WHEN THERE IS NO MEDICARE OR OTHER INSURANCE PRESENT ON THE THIRD PARTY LIABILITY (TPL) COVERAGE FILE LOCATED IN CHAMPS. IF A BENEFICIARY HAS ACTIVE MEDICARE INSURANCE ON CHAMPS, THE NURSING FACILITY MUST ALWAYS REPORT IT, ALONG WITH THE APPROPRIATE VALUE CODES AND CLAIM ADJUSTMENT REASON CODES (CARC).

When reporting Medicare, nursing facilities must bill as indicated below. Medicaid Claims Processing will adjudicate claims based on the new logic effective for claims received on and after February 17, 2012. Replacement claims will also adjudicate utilizing the new logic effective February 17, 2012.

Covered Days

Covered Days must be reported using Value Code 80.

Covered Days are the days in which Medicare approves payment for the beneficiary's skilled care. Covered Days must be reported when the primary insurance makes a payment.

Non-Covered Days

Non-Covered Days must be reported using Value Code 81.

Non-Covered Days are the days not covered by Medicare due to Medicare being exhausted or the beneficiary no longer requiring skilled care. Non-Covered Days must be reported in order to receive the proper Medicaid provider rate payment.

SPECIAL NOTE: When Medicare non-covered days are reported because Medicare benefits are exhausted, facilities must report **Occurrence Code A3** and the date benefits were exhausted, **along with** Claim Adjustment Reason **Codes (CARC) 96** (Non-Covered Charges), **or 119** (Benefit Maximum for the time Period has been Reached).

When Medicare non-covered days are reported because Medicare active care ended, facilities must report **Occurrence Code 22** and the corresponding date Medicare active care ended, **along with** Claim Adjustment Reason **Codes (CARC) 96** (Non-Covered Charges), **or 119** (Benefit Maximum for the time Period has been Reached) must be reported.

Coinsurance Days

Medicare Coinsurance Days must be reported using Value Code 82.

Coinsurance Days are the days in which the primary payer (Medicare or Medicare Advantage Plans) applies a portion of the approved amount to coinsurance. Coinsurance Days must be reported in order to receive the proper coinsurance rate payment.

SPECIAL NOTE: When reporting Value Code 82, Occurrence Span Code 70 (Qualifying Stay Dates for SNF) and corresponding From/Through dates (at least a 3-day inpatient hospital stay which qualifies the resident for Medicare payment of SNF services) must also be reported.

Facilities billing for beneficiaries in a **Medicare Advantage Plan**, must report CARC 2 and this must equal the Medicare Advantage Plan Coinsurance rate times the number of Coinsurance days. Facilities using CARC 2 must report it with the amount equal to the Coinsurance rate times the number of Coinsurance days reported.

SPECIAL NOTE: The Medicare Advantage Plan Coinsurance rates vary and do not always equal the Medicare Part A Coinsurance rate. Providers must verify the beneficiary's Medicare Advantage Plan Coinsurance rate prior to billing Medicaid.

Prior Stay Date

If a SNF or nursing home stay ended within 60 days of the SNF admission, Occurrence Span Code 78 and the From/Through dates must be reported along with Occurrence Span Code 70 and the From/Through dates.

Claim Examples

Nursing facility claim examples on how to report Medicare and Commercial Insurance on the Medicaid Nursing Facility Secondary Claim can be found on the MDCH website at www.michigan.gov/Medicaidproviders, > Provider Tips > Nursing Facility.

SPECIAL NOTE TO NURSING FACILITIES WITH MEDICAID ONLY CERTIFIED BEDS NOT BILLING MEDICARE

Claims submitted directly to Medicaid must be billed as outlined above. For example, for beneficiaries with Medicare coverage based on Medicaid's TPL File, Covered Dates MUST BE LEFT BLANK if Medicare is not covering the service or benefits have exhausted as Medicare is the primary payor. The NON-COVERED DAY MUST BE COMPLETED and it must equal the service units billed for room and board revenue codes and/or leave days revenue codes.

The reason Medicare is not covering the service (e.g., benefits exhausted) must also be reported.

Manual Maintenance

Retain this bulletin until it has been incorporated into the Medicaid Provider Manual.

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 at 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.

Approved

A handwritten signature in black ink that reads "Stephen Fitton". The signature is written in a cursive style with a large, stylized 'S' and 'F'.

Stephen Fitton, Director
Medical Services Administration