Michigan Medicaid Nursing Facility Providers

Billing Information & Reference

Scope/Coverage Codes

- Common Scope Codes
  - 1 – Medicaid
  - 2 – Medicaid
  - 3 – Adult Benefits Waiver
  - 4 – Refugees and Repatriates
- Common Coverage Codes
  - 0 – No Medicaid eligibility/coverage
  - E – Emergency/Urgent Medicaid Coverage Only
  - F – Full Medicaid Coverage
  - G – Adult Benefits Waiver
  - Y– Family Planning Waiver

Beneficiary Eligibility & Admission Process

- Verification of financial Medicaid eligibility
- PASARR Level I screening
- Physician-written order for nursing facility services
- Michigan Medicaid Nursing Facility Level of Care Determination

Medicaid Website

www.michigan.gov/mdch


MDCH
Department of
Community Health
Michigan.gov
An Official State of Michigan Web Site
Michigan.gov Home
MDCH Home | Contact MDCH | Sitemap
Search
GO
Advanced Search
Birth, Death, Marriage & Divorce Records
Physical Health & Prevention
Pregnant Women, Children & Families
Mental Health & Substance Abuse
Health Care Coverage
Statistics & Reports
Providers
Inside Community Health
Health Systems & Health Profession Licensing
Homeland Security
michigan steps up
michiganstepsup.org
Safe Delivery of Newborns
MICHIGAN Mental Health Commission
CLICK FOR MORE INFO
Tax Time Resources
[Printer Friendly]
[Text Version]
A A
What's New
From the Director
Director Janet Olszewski details the steps Michigan is taking to address the potential threat of pandemic influenza.
MDCH Announces Launch Of Michigan Volunteer Registry
Web-based System Raises Level Of Protection For Michigan Citizens
Department to Host Statewide Long Term Care Conference
Where to find information about Medicare Part D Pharmacy Plans
Helpful contact information for beneficiaries and providers
Request for Proposal for Long-Term Care Single Points of Entry PDF
Long-Term Care Single Points of Entry.
Response to Questions Submitted
About our Organization
Meet the Director
Janet Olszewski is Director of the Michigan Department of Community Health (MDCH). The department is responsible for health policy and management of Michigan's publicly funded health systems. Services are planned and delivered through several integrated components.
About the Michigan Department of Community Health
The Michigan Department of Community Health (MDCH) is one of 22 departments of state government.
The department, the largest in state government, is responsible for health policy and management of the state's publicly-funded health service systems. An estimated 1.5 million Michigan residents will ...
Departments & Agencies
State Sponsored Sites
Online Services
Quick Links
Influenza in Michigan
Michigan Medicaid Long Term Care Task Force
Informed Consent for Abortion
Shortcuts to MDCH Web Topics
MDCH Brochures Available for Download
Emerging Diseases
Might I be eligible for benefits? Click here to find out
Local Health Department Map
GENDIS - Genealogical Data
Aging Services - MiSeniors.net
News Releases
Michigan's State Planning Project for the Uninsured.
Community Collaboratives
MDCH Online Services
MiRx Prescription Savings Program
Health Professions Licensing & Regulation

Edit View Favorites Tools Help

Back Search Favorites

http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546-153200--,00.html

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Customize Links Windows Media HRMN MDCH Mich Contact Directory Yahoo! State of Michigan-DCH Login 4IRANY.COM MDCH -

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, Death, Marriage and rce Records
ical Health & ention

Printer Friendly Text Version Email Page A- A+ Text Size

MEDICAID

Medicaid is a federal and state funded health care program that provides comprehensive health care coverage for the medically indigent. This page supplies coverage, billing and reimbursement policies and other important information for enrolled providers. Much of the information provided also applies to other heath care programs administered by MDCH (e.g., Adult Benefits Waiver, MOMS, Plan First!, Children's Special Health Care Services, etc.)

HOT TOPICS

- CHAMPS
- Provider Updates

one Trusted sites

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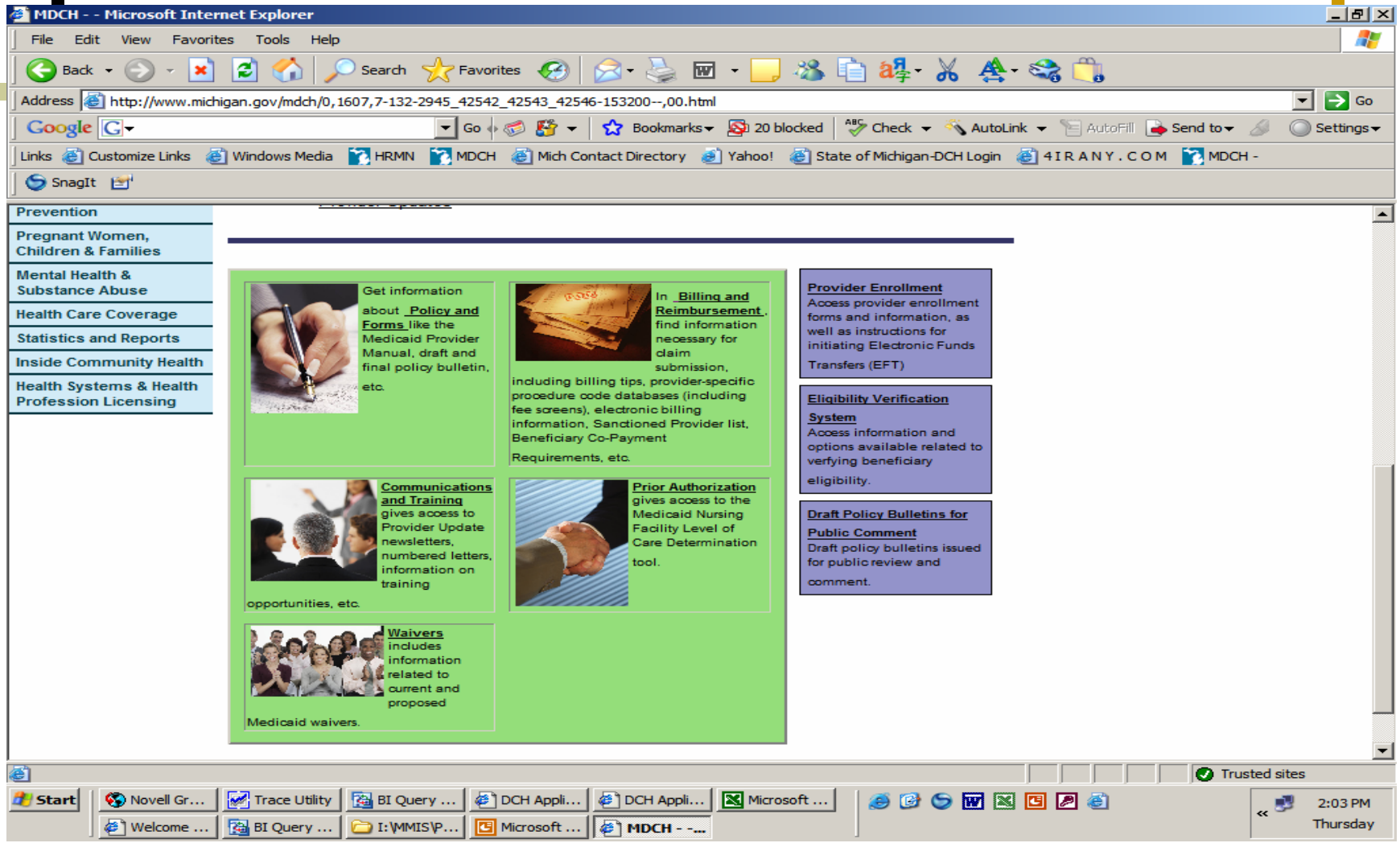
MDCH - - Microsoft Internet Explorer
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Address http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546-153200--,00.html
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Links Customize Links Windows Media HRMN MDCH Mich Contact Directory Yahoo! State of Michigan-DCH Login 4IRANY.COM MDCH -
SnagIt
Prevention
Pregnant Women, Children & Families
Mental Health & Substance Abuse
Health Care Coverage
Statistics and Reports
Inside Community Health
Health Systems & Health Profession Licensing
Get information about Policy and Forms like the Medicaid Provider Manual, draft and final policy bulletin, etc.
In Billing and Reimbursement, find information necessary for claim submission, including billing tips, provider-specific procedure code databases (including fee screens), electronic billing information, Sanctioned Provider list, Beneficiary Co-Payment Requirements, etc.
Communications and Training gives access to Provider Update newsletters, numbered letters, information on training opportunities, etc.
Prior Authorization gives access to the Medicaid Nursing Facility Level of Care Determination tool.
Waivers includes information related to current and proposed Medicaid waivers.
Provider Enrollment
Access provider enrollment forms and information, as well as instructions for initiating Electronic Funds Transfers (EFT)
Eligibility Verification System
Access information and options available related to verfying beneficiary eligibility.
Draft Policy Bulletins for Public Comment
Draft policy bulletins issued for public review and comment.
Trusted sites
Start
Novell Gr... Trace Utility BI Query ... DCH Appli... DCH Appli... Microsoft ...
Welcome ... BI Query ... I:\MMIS\P... Microsoft ... MDCH - -...
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Medicaid Billing & Reimbursement

Provider Updates

- Biller “B”Aware
  - Current Medicaid issues (RAM Notices)
- Newsflash
  - Important upcoming dates
- Provider Inquirer Newsletter
- Medicare Crossover Information
- Provider Tips
  - Tips for specific provider groups

Provider Enrollment /CHAMPS

- Contact Information:
  - Phone: 1-517-335-5492
  - Fax: 1-517-241-8233
  - E-Mail: ProviderEnrollment@michigan.gov
  - P.O. Box 30238
Lansing, MI 48909
  - Champs Hotline # 1-888-643-2408
- Provider ID will be disenrolled if mail is returned
- Report changes in Provider ID on CHAMPS
  - Tax ID, Address, Specialty, Services, etc.
- Electronic Funds Transfer (EFT)
www.migov/cpexpress or ph# 1-888-734-9749
  -

Medicaid Online Manual

- Viewable in Adobe Acrobat Reader
  - Version 5.0 or higher
- Updated Quarterly on Website
  - New quarterly information highlighted
- New CD's are only sent yearly
- Directory Appendix

Medicaid Policy Bulletins and Proposed Changes

- All Bulletins posted online
- Posted by Issue Date
- Proposed Policy Bulletins posted
  - 30 day Public Comment Period
  - Request form available to Participate in Policy Proposal Review

Provider Specific Information

- Fee Screens
  - Medicaid Covered Procedure Codes
  - Medicaid Fees
  - Modifiers Required
  - Documentation Requirements
  - PA Requirements
- Refer to the Instructions document for specific coding information

Explanation Codes

- MDCH has their own list of edit codes on our website
- Identifies status of claim
  - Paid
  - Pend
  - Reject
- Informational Edits
  - Appear with an “X” after the edit

Nursing Facility Top Reasons for denial of claims

- **Edit 682** –
  - The electronic Michigan Medicaid Nursing Facility Level of Care (LOC) Determination was not completed for this beneficiary,
  - Or The LOC Determination was completed, but the beneficiary was determined not eligible for nursing facility level services,
  - Or The LOC Determination was completed, but not within 14 days of admission,
  - Or The screening was completed, but the facility did not enter the beneficiary's Medicaid ID number in the on-line LOC Determination.

682 continued

- **Edit 682/Resolution -**
  - Date of service (DOS) April 1, 2005 and after provider must enter the beneficiary ID# on the determination. Unless this is completed, the determination is not considered complete.
  - The facility can enter the Medicaid ID number in the on-line LOC Determination by going to the Determination Welcome Screen, select “ADD BENEFICIARY ID” and then re-bill the claim.

Nursing Facility Rejections

- **Edit 110** – The Level of Care (LOC) shown on the claim does not match the LOC on the Eligibility Verification System (EVS) for this beneficiary.

- **Resolution -**
  - LOC should change to 02 for all dates of service.

Nursing Facility Rejections

- **Edit 317** – The relationship between the beneficiary's Level of Care (LOC) and the provider type is invalid.

- **Resolution** -
  - Anymore than one day overlap for LOC other than 02 is incorrect with the exception of LOC 10.
  - For LOC 16, bill ***only*** ancillary charges (non-room charges).
  - When LOC changes from nursing facility (NF) (02) to Hospice (16), be aware that Medicaid will ***NOT*** pay NF.
  - LOC 16 can only be changed by DCH, not a DHS caseworker.

Nursing Facility Rejections

- **Edit 264** -The discharge status code is missing.

- **Resolution -**
  - Patient status code must be reported (F.L. 17 paper or Loop 2300, Segment CL1 for electronic).

Nursing Facility Rejections

- **Edit 188** -There is no authorization for long-term care on EVS for at least one of the dates covered by this claim.

- **Resolution** -
  - LOC should change to 02 for the entire date of service.
  - Contact beneficiary's DHS worker.

Nursing Facility Rejections

- **Edit 006** – The provider was not enrolled as an eligible provider on the date(s) of service (DOS).

- **Resolution -**
  - The provider should verify the DOS and the date the provider became an enrolled provider (using Champs website).
  - The claim should be re-billed if the date of provider enrollment is prior to, or on, date of service.
  - Call Provider Enrollment for enrollment issues at 1-517-335-5492 or **providerenrollment@michigan.gov**

Note: Change in Tax ID number results in a change in Provider ID number.

Nursing Facility Rejections

- **Edit 023** – The beneficiary was not eligible for Medicaid or Adult Benefit Waiver coverage on the date(s) of service.

- **Resolution -**
  - Check coverage for DOS.
  - Contact beneficiary's DHS caseworker in the event of discrepancy.

Nursing Facility Rejections

- **Edit 332** – The number of days billed in the From and Through dates does not equal the number of total days on the claim lines.

- **Resolution -**
  - Calculate From and Through dates and add the day of discharge if discharge status is 30 or 20; otherwise, if the patient was discharged **DO NOT** count the last date.

158 Edit (billing limitation)

- The claim was received by MDCH more than one year after the date of service (DOS)
- Resolution-
  - Medicaid Manual
    - General Information for Providers, Section 10.3
  - Claims must be submitted and acknowledged by MDCH within 365 days from DOS.
  - For any claim submitted after 365 days, there MUST be a prior active claim within the last 120 days.

158 Edit (billing limitation)

- Example:
  - DOS = 3/1/04
  - Claim submitted on 1/28/05
  - Claim received by MDCH 2/1/05
  - Claim rejected by DCH on 2/12/05
  - If the claim is not submitted and acknowledged again before 3/1/05, which is the 365 day limit, the claim must be submitted and acknowledged within 120 days from 2/12/05 to keep the claim active.

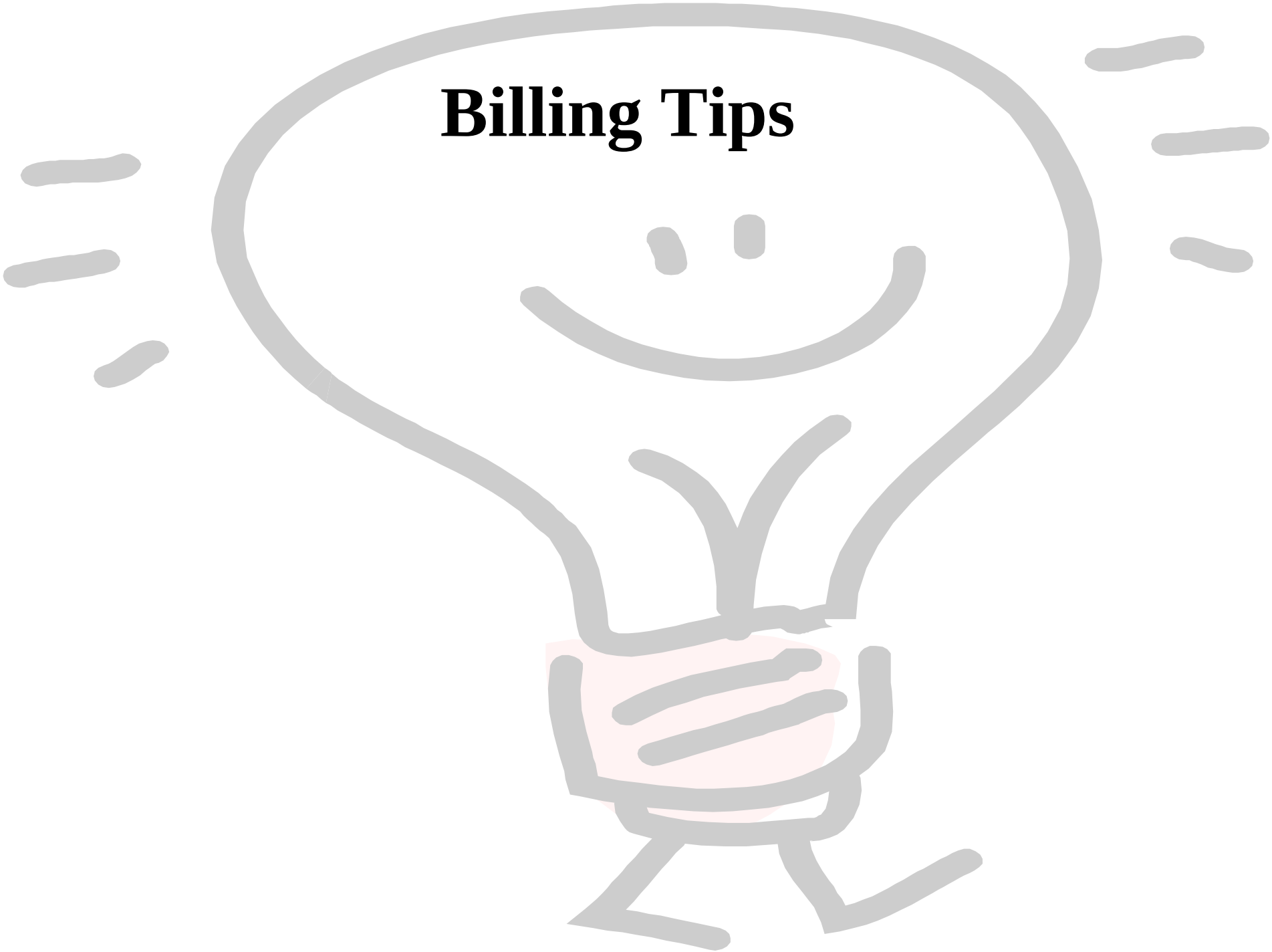
Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

Example: 120 Days
6100-6220

Edit 158 (billing limitation)

- Continue tracking rejections back until either a CRN indicates receipt by MDCH prior to one year from the DOS or a gap of more than 120 days is found.
- If Medicare paid your claim late MDCH will use the Medicare payment date as an exception. The exception is that Medicaid must be billed within 120 days of Medicare's payment. Report the date of Medicare EOB in the remarks section of the claim.

Billing Tips



Billing Tips – Hospital Leave Days

- For hospital leave days (Example: 9/5/05 through 9/7/05), NF should not discharge and readmit patient if the facility is under 98% occupancy: “Note: do not round up in the 98% occupancy”

- If Leave of Absence (LOA) = 2 days, (F.L. 36 for paper or Loop 2300, Segment HI with qualifier BI for electronic) span code 74, 090505 through 090605.

- (F.L. 6 for paper or Loop 2300, Segment DTP with qualifier 434 for electronic) DOS 9/1 through 9/30 with Revenue Code (RC) 0120 = 28 units and (F.L. 17 for paper or Loop 2300, Segment CL1 for electronic) patient status code 30.

Billing Tips – Hospital Leave Days

- Hospital Leave days are to be billed:
  - Up to 10 hospital leave days.
  - RC 0185
  - Occurrence span codes 74 in (F.L. 36 for paper or Loop 2300, Segment HI with qualifier BI for electronic) with the dates of leave.
  - In the event that more than two episodes of hospital leave days need to be reported, the additional episodes must be reported as Occurrence span Code 74 in both (F.L. 35 for paper or Loop 2300, Segment HI with qualifier BH for electronic). To report additional episodes use (F.L. 33 and 34 for paper or Loop 2300, Segment HI with qualifier BH for electronic).
  - Separate claim lines are ***required*** for multiple occurrence hospital leave days in any one month.

Billing Tips – Therapeutic Leave Days

- **Therapeutic Leave days are to be billed:**
  - Up to 18 therapeutic leave days per ***12-month span***
  - RC 0183
  - Occurrence span codes 74 in (F.L. 36 for paper or Loop 2300, Segment HI with qualifier BI for electronic) with the dates of leave.
  - In the event that more than two episodes of therapeutic leave days need to be reported, the additional episodes must be reported as Occurrence span Code 74 in both (F.L. 35 and 36 for paper or Loop 2300, Segment HI with qualifier BH for electronic), F.L. 33 and 34 for paper would be used to report additional episodes.
  - Separate claim lines are ***required*** for multiple occurrence therapeutic leave day spans in any one month.

Billing Tips

- If a beneficiary is discharged and then readmitted to the same NF, report new admission date in F.L. 12 for paper or Loop 2300, Segment DTP with qualifier 435 for electronic.
- Admission date must be completed even if the claim contains only ancillary services.
- Service date must be reported on the claim line for all services except for Room/Board charges.

Billing Tips

- Provider must report the number of covered days by the primary provider in F.L. 6 for paper or Loop 2300,Segment QTY01 for electronic.
- Provider may split bill Room/Board from ancillary services.
- CPT/HCPCS codes are required for all services other than Room/Board and Oxygen.
- Room/Board and oxygen services may be series.

Billing Tips (on One Day Stays)

- A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and in the same day, is discharged from that facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider.

- The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.

Billing Tips

- Only one calendar month is to be billed on a NF claim.
- Facilities must report the total patient-pay amount on the first claim. If there is any remaining patient-pay amount, the amount must be reported on the second claim.
- The total patient-pay amount is not to be reported on both the first and second claims.

Billing Tips on Patient-Pay

- If a beneficiary with a patient-pay amount resides in more than one Medicaid-certified facility in the same month: The first facility must indicate the Discharge Status as 03.
- The total of value code D3 and the offset must equal the beneficiary patient-pay amount for that given month.
- Value codes 25, 26, 27, 28, 29, 33 and 34 could be used to offset the amount. Medicaid will not subtract the offset amount from the value code reported on the claim.

Billing Tips on Prior Authorizations

- The total number of swing bed care days is limited to 100 days per beneficiary per stay.

- If you have prior authorization for Physical Therapy (PT) & Occupational Therapy (OT), report all PT services with PT prior authorization on one claim and OT services on separate claim with OT prior authorization.

Billing Tips

- County Medical Care Facilities (Provider Type 61) and Hospital Long Term Care Units (Provider Type 62) may bill the following Revenue Codes for ancillary services as indicated:
  - **RC 0160** - For dually eligible beneficiaries who wish to return to their Medicaid bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.
  - Services for NF beneficiaries requiring outpatient PT, outpatient speech pathology, and outpatient OT must be provided and billed under Medicare Part B where applicable, even if no payments are made under Medicare Part A for the NF stay.

Billing Tips

- **RC 0410** - Oxygen services (gas, equipment, and supplies) **are covered when billed by a county medical care facility or hospital long-term care unit.**
- **Medicare/Medicaid** – If Medicare is being billed for the NF stay, neither the NF nor a medical supplier can bill Medicaid for oxygen services.
- Oxygen services are included in the Medicare payment to the facility under Medicare's Prospective Payment System.

Billing Tips –

Worksheet for Determining % of Occupancy

		Example 1	Example 2
A.	Total Licensed Beds (excluding beds in an approved non-available bed plan and/or beds disapproved by MDCH for occupancy)	179	140
B.	Number of Total Licensed Beds Not Occupied (unoccupied beds available for a new resident)	2	7
C.	Beds for Residents on Hospital Leave (Medicaid or private pay is paying to hold the bed)	6	8
D.	Beds for Residents on Overnight Therapeutic Leave	0	10
E.	Total Residents on Leave (C + D = E)	6	18
F.	Adjusted Licensed Beds (A – E = F)	173	122
G.	Number of Residents Physically in Facility (total occupancy minus total residents on leave) (A – B – E = G)	171	115
H.	Occupancy (number of residents physically in facility divided by adjusted bed capacity) (G/F = H)	171 / 173 = 99%	115 / 122 = 94%

Billing Tips

- **Rounding Up to 98 Percent**
  - Do not *round up 97.45 percent - 97.49 percent to 98 percent.*

Billing Tips

- To remove other insurance from Third Party Liability (TPL) file:
  - Phone 800-292-2550 (option 4)
  - Fax 517-346-9817
  - TPL_Health@michigan.gov

Replacement/Void Claim Tips

- Do not submit replacement or void/cancel claim when the entire claim rejected. If the claim is rejected, re-submit the *entire* claim.
- Be sure when claim replacing or voiding to use the ***MOST RECENT APPROVED CRN!*** Claim remarks are always required to explain why the claim is being replaced or void/canceled.
- Only approved claims can be replaced or void/canceled. If the approved amount on any line of a claim states anything other than PEND or REJ, then the claim is considered approved.

Replacement Claims

- Correct Claim Completion instructions apply.
- Replacement claim MUST have same Beneficiary ID and Provider ID of original claim.
- Resubmit claim in its entirety how it should have been submitted originally.
  - Replacement claim will completely replace original claim.
- Use a Claim Replacement Code of “7”.
  - All Electronic Billing: Known as “Claim Frequency Type Code”.
  - UB-04: Known as “Type of Bill, Frequency Code” the last digit will be a 7 in the type of bill . Example: 217, 227, 237 etc.

Replacement Claims

- Submit a replacement claim when:
  - All or part of a claim was paid incorrectly.
  - All or part of a claim was billed incorrectly.
    - i.e. Incorrect Units, Charges, Procedure Code, Date of Service, etc.
- Always use the CRN from the last approved claim when replacing or void/canceling a claim.

Void/Cancel Claims

- Correct Claim Completion instructions apply.
- Void/Cancel claim MUST have same Beneficiary ID and Provider ID of original claim.
- Complete one service line with $0.00 billed.
  - Entire original payment will be debited.
- Use a Claim Replacement Code of “8”.
  - Electronic Billing: Known as “Claim Frequency Type Code”.
  - UB-04: Known as “Type of Bill; Frequency Code” the last digit will be a 8 Example: 218, 228, 238 etc.

Void/Cancel Claims

- Submit a Void/Cancel Claim when:
  - A claim is paid under the wrong provider ID or beneficiary ID.
    - If claim was billed under the wrong provider ID or beneficiary, the same provider ID and beneficiary ID must be used on the void claim. A new claim can be submitted for the correct provider ID/beneficiary ID.
  - The claim was never meant to be submitted.
  - A duplicate claim has paid.
- Always use the CRN from the last approved claim when replacing or void/canceling a claim.

Billing Tips

- If the patient was admitted from the NF to the hospital and remains for more than 10 days, discharge the patient the day the patient was admitted to the hospital.
- Create new LOC Determination tool for **ANY** new admission.

Medicare Buy-In Unit (MDCH)

- The Medicare Buy-In Unit is responsible for:
  - Processing Medicare premium payments for eligible Medicaid beneficiaries.
  - Other Insurance (OI) Coding for Medicare on the Medicaid system.
  - Alien information for Medicaid beneficiaries that are age 65 or over, must have the date of entry forwarded to the Buy-In Unit if the beneficiary has not been in the US for over 5 consecutive years.

Medicare Buy-In Unit

- This is a Resource **for Providers Only**.
- Buy-In determines if MDCH can pay Medicare premium amounts for beneficiaries that cannot afford the payments.
- Beneficiary must have a Medicaid ID and be enrolled with Medicare for the Buy-In Unit to do analysis.
  - Phone: 1-517-335-5488
  - Fax: 1-517-335-0478
  - Email: BuyInUnit@michigan.gov (preferred)
- The Medicare Buy-In Unit is not able to address questions directly from beneficiaries. Beneficiaries should contact their caseworker or the Beneficiary Help Line (1-800-642-3195) with questions.

Medicare Buy-In Unit

- Contact the MDCH Buy-In Unit if the Medicare eligibility information given by MDCH does not match the Medicare eligibility information given by Medicare, **and** the beneficiary
  - A) has enrolled with Medicare before[1], or
  - B) is a legal alien over 65 who has not been in the country for more than 5 years[2].

[1] A beneficiary cannot "Buy-In" through MDCH unless they are enrolled with Medicare.

[2] Aliens cannot enroll in Medicare or Buy-In through MDCH unless they are legal aliens and have been in the country for 5 consecutive years.

QUESTIONS?