

Skilled Nursing Facility Historical Provider Tips

July 18, 2011: Hospital Swing Beds are to report Type of Bill (TOB) as 018x.

July 01, 2011: All Nursing facility providers must report Medicare information if the beneficiary has active Medicare on file, even if Medicare benefit exhausted (billing after 100-day benefit period) or billing for non-skilled level of care.

June 30, 2011: Outpatient County Medical Care Facilities: Report Type of Bill (TOB) as 23X when billing for therapies.

June 23, 2011: Report Covered, Non-Covered and Co-Ins Days based on Primary insurance with Value code 80, 81 and 82.

June 23, 2011: Exhausted Medicare Part A Benefits - Report Occurrence Code A3 and the last date patient had Medicare Part A and report Medicare information with appropriate CARC/Reason Code 119 or 96 and reason why it was not covered by Medicare.

June 23, 2011: Total of units for Room and Board and Leave Days on line level should be equal with number of days reported on FROM and TO Date (UB04 - Form Locator 6).

May 25, 2011: Reporting Leave Days: When billing leave days, FROM/ TO Dates and quantity must be reported on service line.

May 25, 2011: All Nursing facility providers should report Medicare information if the beneficiary has active Medicare on file, even if they are Medicaid only (non Medicare certified bed) facilities.

December 1, 2010: Attention Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, Ventilator Dependent Care Units, Hospice, and Home Health Agencies

The Medical Services Administration has noted that providers are incorrectly reporting OR not reporting other insurance or Medicare on claims to Medicaid.

When billing Medicaid if there is a primary insurance the appropriate other insurance information must be reported on the claim. Below are some of the most common ways to report specific situations with other insurance:

- 1) If Medicare Part A is exhausted report Occurrence Code A3 indicating the last date that benefits are not available.
- 2) If other insurance does not cover the service, or is no longer available to the beneficiary, or there is an invalid insurance code on the Medicaid Eligibility Card, report Occurrence Code 24 or 25 accordingly.
- 3) Use proper CAS codes to identify the information from the Medicare EOB or commercial insurance EOB.

To ensure proper adjudication of the claim and unnecessary denials, appropriate information must be reported. This should take place on all subsequent claims as well as the initial claim.