Inpatient Hospital Overview

August 17, 2021

MDHHS
Michigan Department of Health & Human Services

"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

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Acronyms

Acronym	Definition
3M™ APR-DRG	3M™ All Patient Refined Diagnosis Related Grouper
ACRC	Admissions and Certification Review Contractor
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Grouper
FFS	Fee for Service
HCPCS	Healthcare Common Procedure Coding System
ICD	International Classification of Diseases
IPH	Inpatient Hospital
LTACH	Long Term Acute Care Hospital
MDHHS	The Michigan Department of Health and Human Services
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
NDC	National Drug Code
NUBC	National Uniform Billing Committee
POA	Present On Admission
PPA	Patient Pay Amount
TOB	Type of Bill

General Information

MDHHS defines an Inpatient Hospital(IPH) as a facility which provides medically necessary diagnostic, or rehabilitation services to inpatients.

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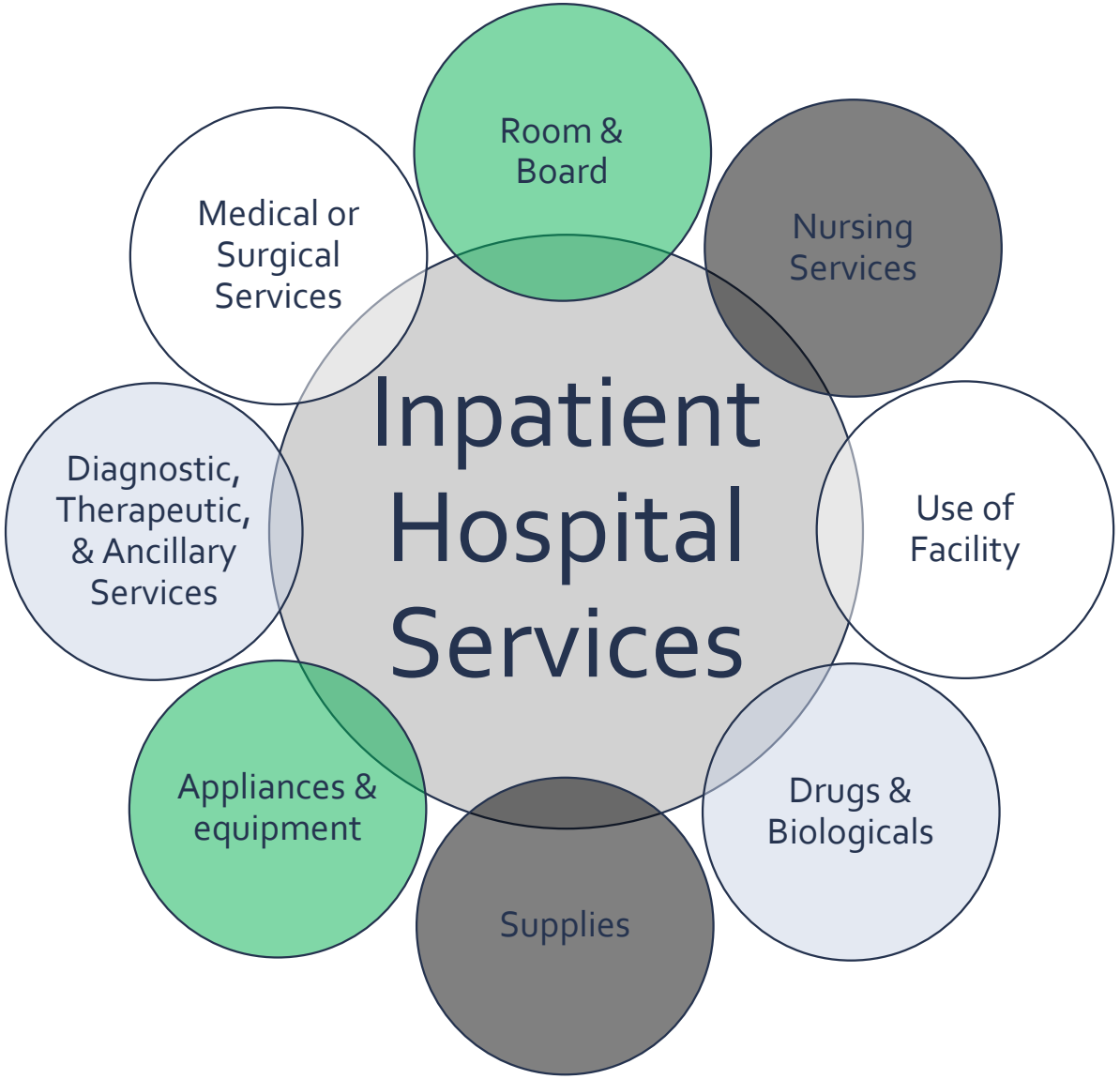
General Information

- Provider Enrollment Instructions
- Medicaid Provider Manual
  - Billing & Reimbursement for Institutional Providers, Section 6 -Hospital Claim Completion
  - Hospital Chapter, Section 1.1- Inpatient Hospital
- Institutional Provider Resources



Services of professionals (e.g., physician, oral-maxillofacial surgeon, dental, podiatric, optometric) are not included and must be billed separately.

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General Information: Reimbursement

- Medicaid Provider Manual,
  - Hospital chapter, Hospital Reimbursement Appendix, Section 2- Inpatient Hospital
- Pricing Inpatient Hospital Claims Tip
- MSA 15-30
- Billing and Reimbursements for Inpatient Hospital Providers
  - DRG Prices & Per Diem Rates
  - Hospital DRG Groupers

- Each inpatient hospital medical/surgical claim received by CHAMPS is assigned a value using the 3M™ APR-DRG.
- Payment Methodologies and factors that can impact 3M™ APR-DRG reimbursement:
  - Outliers
  - Alternate Weights
  - Capital Payment (One rate for entire stay)
  - Short Stay
  - Hospital Acquired Condition
  - Patient Pay Amount

3M™ All Patient Refined Diagnosis Related Grouper (APR-DRG)

- Certain inpatient claim types including Long Term Acute Care Hospital (LTACH), Freestanding Rehabilitation Hospital, and Distinct Part Rehabilitation Units are reimbursed via a Per Diem payment.
- Factors that can impact Per Diem reimbursement:
  - Patient Pay Amount
  - Capital Payment (payment per day)

Per Diem

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Claim Completion

MSA policy should be used in conjunction with the National Uniform Billing Committee (NUBC) Manual when preparing Inpatient Hospital claims.

- NUBC Manual
- Medicaid Provider Manual
  - Billing & Reimbursement for Institutional Providers Chapter, Section 6- Hospital Claim Inpatient

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Claim Completion

- Patient Status and Admission Source codes- Medicare Claims Processing under Pub 100-04
- CHAMPS DDE Institutional Claim Reference Guide
- Inpatient Hospital Claim Completion Guide

- Providers submitting claims electronically must use the ASC X12N 837 5010 institutional format.
- NPI numbers must be reported in any applicable provider loop or field (e.g., attending, billing, referring, and rendering) on the claim.
  - A provider's Taxpayer Identification Number (TIN) will also be used for claim adjudication. Both the NPI and the TIN or Employer Identification Number (EIN) must be reported at the billing provider loop or field.
- Use ICD coding conventions to report the diagnosis code(s) at the highest level of specificity and with the correct number of digits.
- Claims electronically submitted and accepted are received directly into CHAMPS.

Claim Completion: Attending Provider

- Resources:
  - Medicaid Provider Manual Billing & Reimbursement for Institutional Providers, Section 2.3.B -attending Provider
  - Attending Provider Tip
  - Provider Enrollment Webpage

- The attending provider NPI is a requirement for all inpatient hospital claims.
- The attending physician reported on the claim must be Medicaid enrolled and a type 1, individual NPI.
  - A **Type 1** (Individual) NPI is the number associated with an individual healthcare professional (e.g., MD, DDS, CRNA, etc.). The individual may be a sole proprietor or be employed by a clinic, group practice, or other organization. If a sole proprietor, the Type 1 NPI must be reported in the billing provider loop or field of the claim for payment.
- If the attending physician information is not reported on the claim or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.
  - Rendering providers should ensure their referral sources are aware of this requirement.

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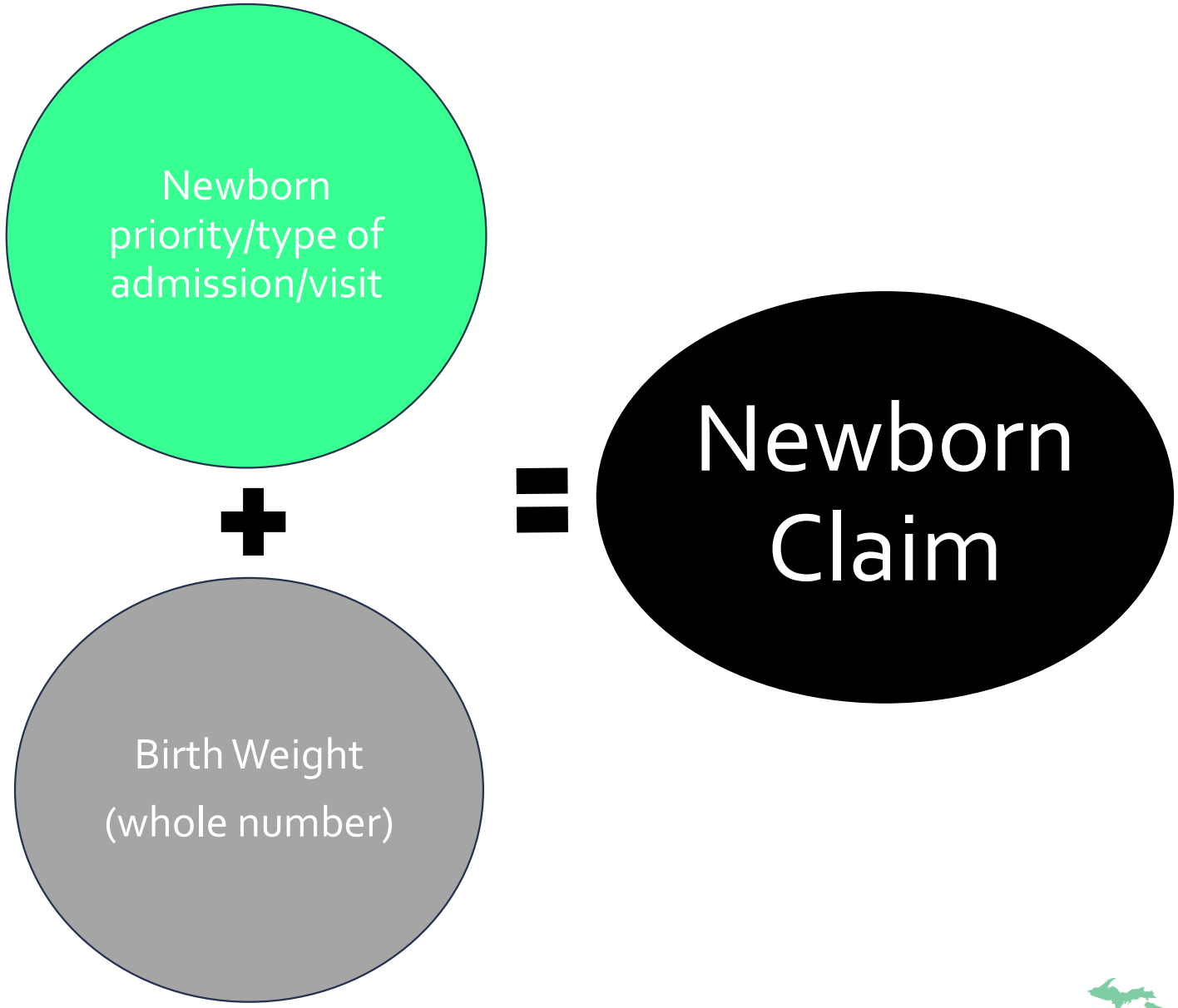
Claim Completion: Beneficiary Eligibility

- Resources:
  - CHAMPS Eligibility Inquiry Quick Reference Guide
  - Benefit Plan & Service Type Codes Table
  - Billing the Medicaid beneficiary

- Changes in Eligibility During Inpatient Stay
  - The payer at the time of admission is responsible for the entire IPH stay until the beneficiary is discharged if there is a change in payer during the stay.
- Hospitals must wait until the beneficiary is discharged from the hospital before a claim can be billed for all services on one claim.
- If a beneficiary loses or gains Medicaid eligibility during a hospital stay, the hospital must bill only for the Medicaid eligible days as follows:
  - The "from" and "through" dates must reflect only the days of Medicaid eligibility.
  - The patient status code must reflect the actual status of the entire admission.
  - The Remarks section must indicate that the beneficiary was Medicaid eligible for a portion of the hospital stay.
  - The admission date must reflect the date the order to admit the beneficiary was written.
  - When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the inpatient hospital claim.

Claim Completion: Newborn Reporting

- MSA 14-34 IPH Claim Requirements for Newborns
- Hospital Claim Newborn Coverage Provider Tip
- Claims failing to report newborn priority or type of admission or visit and newborn birth weight will be denied.
  - Condition codes are required when reporting a cesarean section or induction, as related to gestational age, on the newborn claim.



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Claim Completion: PACER Requirements

- Medicaid Provider Manual
  - Hospital, Section 2.1 - Inpatient Hospital Authorization Requirements
- PACER Requirement Tip

- All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition.
- For claims with dates of discharge on or after October 1, 2014, when an inpatient claim is deemed medically inappropriate or unnecessary through a pre-payment predictive modeling review or a post-payment audit, hospitals are allowed to submit a hospital outpatient Type of Bill (TOB) 013X for all outpatient services and any inpatient ancillary services performed during the inpatient stay.
- Examples of services related to medically inappropriate or unnecessary inpatient admission include:
  - All elective admissions, readmissions, and transfers that are not authorized through the PACER system;
  - Admissions or readmissions which have been inappropriately identified as emergent/urgent;
  - Select ambulatory surgeries inappropriately performed on an inpatient basis; and
  - Any other inpatient admission determined to have not been medically necessary.
- Elective admissions, all readmissions within 15 days of discharge, continued stays (when appropriate), and all transfers for surgical or medical inpatient hospital services to and from any in-state or borderland hospital enrolled in the Medicaid program require authorization through the Admissions and Certification Review Contractor (ACRC).

Claim Completion: 15 Day Readmission

- Resources:
  - PACER Requirement Tip
  - CHAMPS Claim Limit List Tip
  - Medicaid Provider Manual
    - Billing & Reimbursement for Institutional Providers, Section 6.2.C Special Circumstances for Hospital Readmissions and Transfers
  - L Letter -07-02

Readmission within 15 days to the same hospital

(Unrelated)

PACER Required

Medicaid considers the case a new admission and the claims are billed separately.

Occurrence Span Code 71

"from" and "through" dates of the previous admission

(Related)

No PACER Required

Medicaid considers this one episode of care, and the admissions must be combined.

Occurrence Span code 74

"from" and "through dates of the leave of absence

Readmission within 15 days to a different hospital

PACER required

Occurrence span code 71

"from" and "through" dates of the previous admission

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Claim Completion: Psychiatric/ Detoxification

- Medicaid Provider Manual
  - Behavioral Health and Intellectual and Developmental Disability Chapter, Section 8- Inpatient Psychiatric Hospital Admissions
  - Hospital Chapter, Section 3.21- Mental Health and Substance Abuse Services
  - Medicaid Health Plan Chapter Section 2.9- Substance Abuse
- Psychiatric Admissions Billing

- Due to the complex reimbursement system, it is imperative for providers to work closely with the Medicaid Health Plans (MHP), Medicaid Fee for Service (FFS) and the Prepaid Inpatient Health Plans (PIHP) when planning to admit any patient to an inpatient status.
- **Inpatient Psychiatric Services** – The PIHP is responsible for mental health services in a community-based psychiatric inpatient unit for all Medicaid beneficiaries.
- **Acute Inpatient Medical Detoxification** – Medically necessary inpatient detoxification services are covered only in a life-threatening situation. Acute detoxification services are reimbursed directly through MDHHS for both MHP enrollees and FFS beneficiaries.

Common Claim Suspends & Denials

CHAMPS may suspend or deny claims based on State of Michigan documentation or coding requirements. Claims may also suspend for prepayment editing known as Predictive Modeling.

Reason and Remark code definitions: https://x12.org/reference

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Common Claim Suspends

- Additional Resources:
  - A8 Claim denial
  - CHAMPS External Links
  - Common Hospital Claim Denials
  - ICD-10 Surgical Codes with Documentation Requirements
  - Predictive Modeling Provider Tip
  - Suspended Claim Tip
  - Timely Filing Tip

Reason Code (CARC)	Remark Code (RARC)	Resource
197 - Precertification/authorization/notification/pre-treatment absent.		Pacer Requirements
45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N219 - Payment based on previous payer's allowed amount.	Claim will suspend so the other insurance payment and processing information can be reviewed. • Other Insurance Coverage Type Codes • Other Insurance Reporting Requirements
133 - The disposition of this service line is pending further review.	N47 - Claim conflicts with another inpatient stay.	• PACER Requirement Tip • CHAMPS Claim Limit List Tip • Medicaid Provider Manual • Billing & Reimbursement for Institutional Providers, Section 6.2.C Special Circumstances for Hospital Readmissions and Transfers
133 - The disposition of this service line is pending further review.		ICD 10 Surgical Procedure Codes with Documentation Requirements
96 - Non-covered charge(s).	M2 - Not paid separately when the patient is an inpatient.	• Outpatient Services Prior to Inpatient Admission • Rebilling Hospital Claims • MSA 14-36 • L 14-53

Common Claim Denials

- Additional Resources:
  - A8 Claim denial
  - CHAMPS External Links
  - Common Hospital Claim Denials
  - ICD-10 Surgical Codes with Documentation Requirements
  - Predictive Modeling Provider Tip
  - Suspended Claim Tip
  - Timely Filing Tip

Reason Code (CARC)	Remittance Code (RARC)	Resource
24 - Charges are covered under a capitation agreement/managed care plan.		Verify eligibility and submit charges to correct benefit plan.: • CHAMPS Eligibility and Enrollment Tab Instructions
204 - This service/equipment/drug is not covered under the patient's current benefit plan.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	Verify eligibility: • CHAMPS Eligibility and Enrollment Tab Instructions
22 - This care may be covered by another payer per coordination of benefit.	N598 - Health care policy coverage is primary.	• How to Locate Payer ID and Other Health Insurance Information • Other insurance reporting requirements
16 - Claim/service lacks information or has submission/billing error(s).	M47 - Missing/incomplete/invalid internal or document control number.	Ensure the TCN attempting to be adjusted/voided is in a paid status: • Manage Claims-Adjust/Void
31 - Patient cannot be identified as our insured.		Verify eligibility: • CHAMPS Eligibility and Enrollment Tab Instructions

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Coronavirus (COVID-19) Resources

Visit Michigan.gov/COVIDVaccine for the most recent information on the vaccine in Michigan

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Coronavirus (COVID-19) Resources

MDHHS resources to keep providers informed about the Coronavirus (COVID-19) pandemic and the State of Michigan's response.

- Learn about our responses to Coronavirus (COVID-19) and find the latest program guidance. www.michigan.gov/coronavirus >> Resources >> For Health Professionals

- Additional Information:
  - COVID-19 Response Database
  - Telemedicine Database
  - COVID-19 Response MSA Policy Bulletins

- Questions About COVID-19?
  - Visit our Frequently Asked Questions page
    - Our most commonly answered questions can be found there and are updated often.
  - Call the COVID-19 Hotline at 1-888-535-6136
  - Email COVID19@michigan.gov

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Provider Resources

MDHHS website:
www.michigan.gov/medicaidproviders

We continue to update our Provider Resources:

- CHAMPS Resources
- Listserv Instructions
- Medicaid Provider Training Sessions
- Provider Alerts
- Provider Enrollment Website

Provider Support:

ProviderSupport@Michigan.gov

1-800-292-2550

Thank you for participating in the Michigan Medicaid Program