MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Nursing Facilities 02-02
Nursing Home Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Units (Provider Type 63)
Nursing Facilities for the Mentally Ill (Provider Type 72)
Outpatient County Medical Care Facilities (Provider Type 64)

Issued: July 1, 2002

Subject: Uniform Billing
Revised Chapter IV
Billing Codes Appendix

Effective: October 1, 2002

Programs Affected: Medicaid

PURPOSE

Effective October 1, 2002, the Michigan Department of Community Health (MDCH) is implementing changes in coverage, reimbursement policies, and claim submission requirements for nursing facilities as part of its Uniform Billing Project (UBP). These changes will align MDCH requirements with those of other major health insurers and are a step toward HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance. This bulletin, and the revised accompanying Chapter IV and Billing Codes Appendix, reflects these changes.

Chapters III and VII, as appropriate, of the Nursing Facility Manual will be revised at a later date to reflect changes in policy related to the UBP. These changes include:

- elimination of Michigan Local (Procedure) Codes;
- elimination of separate reimbursement for dialysis transportation; and
- clarification of the type of nursing facilities that may bill Medicaid for the co-insurance and deductible for services covered by Medicare Part B.

Note: Policies not related to the UBP remain in effect.

Copies of all draft or final policy bulletins, the electronic claim transaction set, and other information related to changes being made are available on the MDCH website at: www.michigan.gov/mdch *click on Providers, Information for Medicaid Providers, Medicaid Policy.*

CLAIM FORMATS

You may submit your claims electronically or on paper. However, electronic claim submission is the method preferred by MDCH. Claims submitted electronically are entered directly into the Claims Processing System resulting in faster payments, and fewer pends and rejects. Claims can be submitted by file transfer or through the data exchange gateway.

The preferred electronic format is the Michigan Medicaid Version of the National Electronic Data Interchange Transactions Set Health Care Claim: Institutional 837 (ASC X12N 837, version 4010). The MDCH encourages you to use this format as soon as possible. Up to the HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance effective date, MDCH will also accept the UB-92 EMC 5.0.

Information on submission of electronic claims using the Michigan Medicaid Institutional Version 4010 (ASC X12N 837) format is available on the MDCH website at: www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Michigan Medicaid Uniform Billing Project, Electronic Claims Submission Information. This website contains helpful information on electronic billing. **Note:** This site does not contain The National Electronic Data Interchange Transaction Set Implementation Guide. The guide can be downloaded from the web at: www.wpc-edi.com/hipaa/hipaa_40.asp. (Note: There is an underscore_between hipaa and 40.asp)

To submit electronic claims using the UB-92 EMC 5.0, see the revisions to the Medicaid Electronic Billing Manual. These revisions are being sent to all providers that currently have an active electronic billing ID number with MDCH. If you do not currently bill electronically, contact the Automated Billing Coordinator for the MDCH. The Electronic Billing Manual is available on the MDCH website at: www.michigan.gov/mdch, Providers, Information for Medicaid Providers, Michigan Medicaid Uniform Billing Project, Electronic Claims Submission Information. The Electronic Billing Manual, UB-92 Manual and the Nursing Facility Manual, Chapter IV, are used when billing.

For more information on electronic billing:

E-mail: AutomatedBilling@Michigan.Gov

Write to: Michigan Department of Community Health
Medicaid Automated Billing Coordinator
P. O. Box 30043
Lansing, MI 48909–7543

Telephone: 1-800-292-2550

Note: Currently, the MDCH has a cooperative agreement with Blue Cross and Blue Shield of Michigan (BCBSM) that allows nursing facilities to use the BCBSM EPIC system to submit Medicaid nursing facility claims. BCBSM will forward these claims to MDCH within one business day. For additional information, contact BCBSM at (248) 486-2445.

If you submit claims on paper, the UB-92 claim form must be used. Paper claim completion instructions are contained in the attached Chapter IV.

Nursing facilities must use the UB-92 paper claim form (HCFA 1450) or one of the two associated electronic claim formats on and after October 1, 2002. These formats must be used regardless of the date of service. These formats must also be used for adjusting services on and after October 1, 2002, even though services may have been previously paid using the old billing forms.

Testing of paper and electronic claim formats are proposed to begin in July 2002 and will continue through September 13, 2002. This testing period will allow nursing facilities and the MDCH time to detect and correct any problems that might occur with the conversion to the new formats. A letter indicating the instructions for claims testing was issued to nursing facilities in May 2002. Copies of the testing instructions are available on the MDCH website.

BILLING INSTRUCTIONS

Nursing facilities must use the UB-92 Manual for completing the UB-92 claim form. Medicaid billing instructions for completing the UB-92 will be incorporated into the UB-92 Manual, along with Medicaid claim examples. The attached Chapter IV, Section 3, contains additional billing information not included in the UB-92 Manual. This chapter has also been reformatted and updated to conform to Medicaid's current processes and information related to billing and reimbursement.

A facility that needs a UB-92 Manual may obtain one as instructed in the attached Chapter IV, Section 1.

PROCEDURE CODES

Effective for all claims received on and after October 1, 2002, regardless of the date of service, services must be billed on the new claim formats with revenue codes and, if appropriate, supporting procedure codes.

Effective for all claims received on and after October 1, 2002, nursing facilities are NOT to bill using the local codes listed in the current Appendix F of the Medicaid Nursing Facility Manual with the **exception of dialysis transportation** as detailed later in this bulletin.

- **PHYSICAL/OCCUPATIONAL THERAPY & SPEECH PATHOLOGY**

  The Billing Codes Appendix lists the revenue codes and corresponding CPT/HCPCS codes that may be billed to Medicaid for physical and occupational therapy and speech pathology.

  NOTE: The change to CPT/HCPCS codes will bring the MDCH in line with how other insurers bill for therapies. Nursing facilities will be reimbursed off the CPT/HCPCS codes and the reimbursement rate will be the same as the Medicaid rate paid to outpatient hospitals that provide these therapies. **Exception:** Medicaid's reimbursement rate for speech pathology HCPCS Code G0195 and CPT Codes 92526 and 92597 will be reimbursed the same as Medicaid-enrolled hearing and speech centers.

  NOTE: When completing Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization, **MSA – 115**, for dates of service on and after October 1, 2002, the facility must use the CPT/HCPCS code(s), as listed in the attached Billing Codes Appendix. The attached Chapter IV contains instructions on the completion of the MSA–115.

- **OTHER SERVICE REVENUE CODES**

  The OTHER SERVICE REVENUE (PROCEDURE) CODES in Appendix F have been replaced with the attached Billing Codes Appendix. The Billing Codes Appendix now contains only two Other Service Revenue Codes:

  - Revenue Code 0250 – Pharmacy: This revenue code is covered when billed by a hospital long term care unit. County medical care facilities must enroll as a pharmacy, Provider Type 50 or have a Medicaid-enrolled pharmacy bill Medicaid.
  - Revenue Code 0410 – Oxygen: This revenue code is for oxygen services (i.e., gas, equipment, supplies). This revenue code is covered when billed by a county medical care facility or a hospital long term care unit.

    Medicare/Medicaid – If Medicare is being billed for the nursing facility stay, neither the nursing facility nor a oxygen supplier can bill Medicaid for oxygen services (i.e., gas, equipment, supplies). Oxygen services are included in the Medicare payment to the facility under Medicare's Prospective Payment System.

All other service codes have been eliminated. The codes were eliminated because they are included in the facility's per diem rate (e.g. medical supplies) or are ancillary services that must be provided and billed by the appropriate enrolled provider (e.g., laboratory, radiology, physician).

NOTE: Long Term Care Facilities 96-04 bulletin (Wound Dressings) remains in effect. The wound dressings identified in the bulletin must be obtained through a medical supplier and are not included in the facility per diem rate.

For Other Service Procedure Codes that have been eliminated, but the facility has charges for dates of service prior to October 1, 2002, the facility must bill the appropriate revenue code(s) listed below.

Description	Revenue Code
Pharmacy	0259
Medical/Surgical Supplies	0279
Oxygen	0419
Emergency Room	0459
Blood	0389
Operating Room	0369
Radiology	0359
Laboratory	0309
EKG	0929
Cancer Chemotherapy	0269
Physician Services	0960
EEG	0929
Other Medical-Surgical Services	0279

- **OTHER SERVICE PROCEDURE CODES FOR MEDICARE PART B CO-INSURANCE AND DEDUCTIBLE AMOUNTS**

The Billing Codes Appendix contains revenue codes that may be billed to Medicaid for Medicare Part B co-insurance and deductible amounts. When billing, each claim line also requires a CPT/HCPCS code.

- **ELIMINATION OF SEPARATE REIMBURSEMENT FOR DIALYSIS TRANSPORTATION**

For dates of service on and after October 1, 2002, Medicaid will no longer make separate payment to a nursing facility for dialysis transportation for Medicaid beneficiaries. This will bring Medicaid in line with other insurers who do not make separate payment for transportation.

Note: For dialysis transportation charges for dates of service prior to October 1, 2002, the facility must bill Revenue Code 0889 and one of the following procedure codes: 699107, 699108, or 699109 in Form Locator (F.L.) 44.

Effective October 1, 2002, reimbursement for dialysis transportation is included in the facility's routine nursing care per diem rate. Only nursing facilities that incurred and reported dialysis patient transportation costs in their cost report will be paid a reimbursement rate add-on transportation cost in the facility per diem reimbursement rate. This reimbursement will reflect the historical dialysis transportation payment.

Reimbursement for dialysis transportation will be included in the facility's routine nursing care per diem rate as follows:

- *Add–on reimbursement per diem for rate years already in effect as of October 1, 2002.* A nursing facility that reported dialysis patient transportation cost in the prior year cost report, on which the facility reimbursement rate for the current year is based, will qualify for a per diem rate add-on reimbursement to the facility's established rate. The nursing facility with a reimbursement rate year beginning prior to October 1, 2002 will be paid a per diem rate add–on amount for the balance of the facility's rate year if the facility had previously incurred reported dialysis patient transportation. If the nursing facility rate year begins on or after October 1, 2002, and the nursing facility's cost report year on which the new rate is based is prior to September 30, 2001, the nursing facility will qualify for this rate add-on if the facility had previously incurred reported dialysis patient transportation. The add-on will be a per patient day amount determined from the cost base historical cost report data. The amount will be equal to the dialysis patient transportation cost removed from routine nursing care divided by the greater of the patient days census or 85% occupancy census days for the cost report time period. The add-on will be incorporated into the facility's prospective rate for the time period October 1, 2002 through the end of the current rate year, or until such time as a cost report period ending on or after September 30, 2001 is the basis for the nursing facility rate.
- *Reimbursement included in the rate for the facility for the rate year beginning on and after October 1, 2002.* Nursing facility rate years beginning on and after October 1, 2002 will be based on cost report data which will include incurred dialysis patient transportation in the historical cost of routine nursing care. Effective for cost report periods ending on and after September 30, 2001, the nursing facility will not be required to remove dialysis patient transportation cost from routine nursing care cost for Medicaid Program cost reporting. Inclusion of these costs in the routine nursing care cost base will provide for reimbursement of the cost as part of the routine nursing care per diem for the rate period beginning on or after October 1, 2002. The nursing facility that has previously filed the cost report for the fiscal reporting period ending on or after September 30, 2001 will be afforded the opportunity to amend the filed cost report to include the cost for routine nursing care. The MDCH will review previously submitted cost reports to provide notice to nursing facility representatives to amend the cost report in cases where the nursing facility incurred and reported dialysis patient transportation cost adjustment.
- *No rate adjustment.* The nursing facility that did not incur dialysis patient transportation in the historical cost year ending prior to September 30, 2001 will not be eligible for the add-on reimbursement amount.
- *Level 1 or Level 2 special rate relief for services prior to October 1, 2002.* Medicaid reimbursement for routine nursing care services provided prior to October 1, 2002; and based on cost report data for the fiscal year ending on or after September 30, 2001; will not include the dialysis patient transportation cost. The reimbursement of these costs applicable to Medicaid-eligible patients would have been made through direct billing and claim processing for these services.

PRIOR AUTHORIZATION TO OFFSET THE PATIENT-PAY AMOUNT FORM

Information in the current Chapter IV regarding Prior Authorization to Offset the Patient-Pay Amount form (MSA-1633) for non-covered services has been eliminated. Instead of the submission of this form for approval to offset the patient-pay amount for non-covered services, the provider must call the MDCH, Health Programs Administration, at (517) 241-4293 for approval. Chapter III of the Nursing Facility Manual will be revised at a later date to include this change.

COMPLEX CARE MEMORANDUM OF UNDERSTANDING (MOU)

As a result of the UBP, MOU authorization letters will contain a nine-digit prior authorization number. As indicated in Chapter IV, Section 3, the authorization number must be entered on the UB-92 claim form.

THIRD PARTY BILLING

As indicated in the attached Chapter IV, nursing facilities are reminded that federal regulations require Medicaid providers to bill all available third-party resources prior to billing Medicaid.

MANUAL MAINTENANCE

The attached Chapter IV must be used for claims submitted on and after October 1, 2002, and should be inserted into the manual at that time. Providers may wish to retain the existing Chapter IV for reference for billing prior to October 1, 2002.

Effective October 1, 2002, replace the current Appendix F with the attached Billing Codes Appendix.

The nursing facility may discard Long Term Care Facilities 97–02 bulletin.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Support, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVED

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INTRODUCTION

This chapter contains information needed to submit claims to the Michigan Department of Community Health (MDCH) for Medicaid. It also contains information on claims processing.

Providers are encouraged to bill electronically to receive faster payment and fewer pends and rejections. The preferred electronic format is the Michigan Medicaid Interim Version of the National Electronic Data Interchange Transactions Set Health Care Claim: Institutional 837 (ASC X12N 837, version 4010). Up to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance effective date, MDCH will also accept the UB-92 EMC 5.0 format.

CLAIMS PROCESSING SYSTEM

All submitted claims are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically. The MDCH encourages claims to be sent electronically by file transfer or through the data exchange gateway. Electronic filing is more cost effective, more accurate, and payment is received quicker.

The CP System consists of several cycles:

- **The daily cycle** is the first set of computer programs to process all claims (paper and electronic). The daily cycle is run five to six times each week and performs a variety of editing (e.g., provider and beneficiary eligibility, procedure validity). All claims are reported out as pended, rejected, or tentatively approved.
- **The weekly cycle** is run once each week using the approved claims from the daily cycles that were run during the previous six days. The weekly cycle edits claims against other paid claims and against certain reference files. Weekly editing includes duplicate claims, procedures with frequency limitations, etc. The provider's check (warrant) and remittance advice (RA) are also generated from this cycle. All claims are reported out as pended, rejected, or approved for payment.

REMITTANCE ADVICE

Once claims have been submitted and processed through the CP System, a remittance advice (RA) is sent to the provider and to the billing agent, if applicable. The RA section (Section 7) of this chapter contains additional information about the RA.

ADDITIONAL RESOURCE MATERIAL

Medicaid Provider Manual: This manual contains Medicaid policy and special billing information. The manual is available at a nominal cost from the MDCH and can be ordered by calling (517) 335-5158.

HCPCS Codes: The Health Care Financing Administration Common Procedure Coding System (HCPCS) lists national codes and must be purchased annually. This publication is available from many sources, such as the AMA Press at 1-800-621-8335 or Medicode at 1-800-999-4600.

CPT Codes: The CPT (Physicians' Current Procedural Terminology) coding manual is available from many sources, such as the AMA Press at 1-800-621-8335 or Medicode at 1-800-999-4600.

UB-92 Manual: This manual may be purchased from the: Michigan Health and Hospital Association, Health Delivery & Finance Department, 6215 W. St. Joseph Hwy., Lansing, MI 48917-4846; telephone (517) 323-3443.

International Classification of Diseases (ICD-9-CM): Diagnosis codes are required on claims using the conventions detailed in this publication. This publication should be purchased annually. It may be requested from Medicode at 1-800-999-4600, or the AMA Press at 1-800-621-8335.

Bulletins: These intermittent publications supplement the Medicaid Nursing Facility Manual. Bulletins are automatically mailed to enrolled providers and subscribers of the Medicaid Nursing Facility Manual. Recent bulletins can be found on the MDCH website.

Numbered Letters: General program information or announcements are transmitted to providers via numbered letter.

Remittance Advice (RA) Messages: As needed, RA messages are sent with the remittance advices and give information about Medicaid policy and payment issues that affect the way you bill and receive payment.

The following materials are supplied by the MDCH for use by the facility:

Facility Admission Notice (MSA-2565C)
Mental Illness/Developmental Disability Identification Criteria (MSA-3877)
Mental Illness/Developmental Exception Criteria (MSA-3878)
Occupational/Physical Therapy-Speech Pathology Prior Approval-Request/Authorization (MSA-115)

A supply Re-Order card is furnished to the facility in each shipment of billing materials. The facility should use this card when ordering specific amounts of the above materials for a three-month period. All Medicaid material requests must include the provider's Medicaid I.D. number and the request must be directed to:

Michigan Department of Community Health
Forms Distribution
Lewis Cass Bldg.
320 S. Walnut St.
Lansing, Michigan 48913

The facility should request **materials at least four weeks prior to the need for these materials.**

Electronic Funds Transfer (EFT): To initiate an EFT, the facility can access the MDCH website at: www.cpexpress.state.mi.us.

Note: The MDCH website is. www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers.

HOW TO FILE CLAIMS

Claims may be submitted **electronically** or on **paper.** Electronic claim submission is the method preferred by the MDCH.

ELECTRONIC CLAIMS

Claims submitted electronically are entered directly into the Claims Processing System resulting in faster payments, and fewer pends and rejects. Claims can be submitted by file transfer or through the data exchange gateway. The preferred electronic format is the Michigan Medicaid Interim Version of the National Electronic Data Interchange Transactions Set Health Care Claim: Institutional 837 (ASC X12N 837, version 4010). Up to the HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance effective date, MDCH will also accept the UB-92 EMC 5.0 format.

Information on submission of electronic claims using the Michigan Medicaid Interim Institutional Version 4010 (ASC X12N 837) format is available on the MDCH website at: www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Michigan Medicaid Uniform Billing Project. For information on submission of the UB-92 electronic claim format, contact the Medicaid Automated Billing Coordinator (see following sub-section.)

AUTHORIZED ELECTRONIC BILLING AGENT

Any biller who submits claims electronically to the MDCH must be an authorized electronic billing agent. A test process must be completed. The test consists of creating a test file of a minimum of 25 new claims and achieving a successful test run of that data through the MDCH Claims Processing System. Additional claims may be required if the testing shows a problem area. The test claims are not processed for payment. Any real claims for services rendered must be billed on paper until the provider has received approval to bill electronically.

Once the systems test has been passed, the billing agent will be issued a written authorization to participate as an electronic billing agent. In the event a provider decides to use a MDCH approved electronic billing agent, the provider must complete and submit to the MDCH a **Billing Agent Authorization (DCH-1343) form**. This form certifies that all the services the provider renders are in compliance with Medicaid guidelines. The MDCH will notify the provider when the DCH-1343 has been processed. At that time, the biller can begin billing electronically for the provider's services. If claims are submitted prior to receiving MDCH authorization, they will be rejected.

Any provider can submit claims electronically as long as a MDCH authorization is received, however, many providers find it easier to use an existing authorized billing agent. Most billing agents will accept claims electronically, on diskette, or on paper. The billing agent takes claim information gathered from all of its clients and formats it to the MDCH standards. The data are then sent to the MDCH for processing. Whether claims are submitted directly by the provider, or through another authorized billing agent, the provider will receive a remittance advice (RA). The billing agent will receive an RA that will contain information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents:

E-mail: AutomatedBilling@MICHIGAN.GOV

Or write to: Michigan Department of Community Health
Medicaid Automated Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

1-800-292-2550

ELECTRONIC CLAIMS WITH ATTACHMENTS

On an electronic record, comments or additional information may be reported in the appropriate segments of the record. Claims with COB, Other Insurance or Medicare do not need attachments. Claims with extraneous attachments must be submitted on paper.

PAPER CLAIMS

When submitting paper claims, use the UB-92 claim form. It must be a red-ink form with UB-92 HCFA-1450 in the lower left corner. Paper claims are scanned by an Optical Character Reader (OCR).

Claims may be prepared on a typewriter or on a computer. MDCH will not accept handwritten claims. The claims are optically scanned and converted to computer data before being processed. Print problems may cause misreads, delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn out ribbons. Mylar (plastic film) ribbon is preferred.

Questions and problems with the compatibility of equipment with MDCH scanners should be directed to the OCR Coordinator at:

Michigan Department of Community Health
Attn: OCR Coordinator - Operations
3423 N. MLK Jr. Blvd.
Lansing, MI 48906

OR

E-Mail Address: OCRCoordinator@MICHIGAN.GOV

GUIDELINES TO COMPLETE PAPER CLAIM FORMS

The following guidelines are to be used in the preparation of paper claims to assure that information contained on the claims is correctly read by the scanning equipment. Failure to adhere to the guidelines may result in processing/payment delays or claims being returned unprocessed.

- Date of birth must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 03212002). All other dates must be six digits. Be sure the dates are within the appropriate boxes on the form.
- Use only black ink. Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12 point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. DO NOT squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use White-Out or correction tape, including self-correction typewriters.
- If a mistake is made, the provider should start over and prepare a "clean" claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, with no folding, in 9" x 12" or larger envelopes.
- Put a return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut edges of forms.
- Keep the file copy for your records.
- Mail UB-92 claim forms separate from any other type of form.

PROVIDING DOCUMENTATION WITH PAPER CLAIM FORMS

When a claim attachment is required, it must be directly behind the claim it supports. Documentation must be on 8 ½ x 11" white paper and be one -sided. Do not submit two-sided material. Multiple claims cannot be submitted with one attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims that have no attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required. Unnecessary attachments will delay processing of your claim.

MAILING PAPER CLAIM FORMS

All paper claim forms and claim forms with attachments must be mailed to:

Michigan Department of Community Health
P.O. Box 30043
Lansing, MI 48909 - 7543

UB-92 CLAIM COMPLETION INSTRUCTIONS

The nursing facility submitting paper claims must bill on the UB-92 claim form using the instructions contained in the UB-92 Manual with the following modifications or reminders.

PATIENT–PAY AMOUNT

➡ ONE FACILITY - TWO CLAIMS

When a nursing facility must submit two claims within the same month for the **same beneficiary who has a patient-pay amount**, **the following instructions must be followed**:

- the claim for the first service dates in the month must be submitted **before** the claim for the remainder of the month, even if the patient–pay amount is equal to or greater than the amount billed, and
- the **first claim must be paid before** submitting the second claim. If the first claim is pended or rejected, and the second claim is submitted and paid, the whole patient-pay amount will be deducted incorrectly from the net amount due on the second claim, even if all or a portion of the patient–pay amount was to have been deducted from the first claim. A replacement claim will be required for the second claim to correct the underpayment after both claims are paid.

NOTE: The facility is to report the total patient-pay amount on the first claim. If there is any remaining patient-pay amount, that 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.

➡ TWO FACILITIES – TWO CLAIMS IN ONE MONTH

If a **beneficiary with a patient-pay amount** resides in more than one Medicaid-certified facility in the same month:

- the first facility must submit a claim:
  - -for the days the beneficiary resided in the facility (even if the amount billed is zero because the amount due is covered by the patient-pay amount),
  - -to be paid for any amount due that is more than the patient-pay amount, and
  - -for the second facility to receive the correct payment.

  NOTE: The first facility must indicate “03”, Discharged/transferred to SNF, in F.L. 22.
- the second facility must indicate “05”, Transfer from a SNF, in F.L. 20, and bill in the usual manner, reflecting the days the beneficiary resided in the facility. The remainder of the patient-pay amount that was NOT used by the first facility, if any, must be entered in F.L. 39 – 41 and the Value Code must be D3.
- if the first claim has not been submitted or is pended or rejected, and the second facility submits its claim, the whole patient-pay amount will be deducted incorrectly from the amount due on the second claim. The second facility will need to submit a replacement claim in order to receive its proper payment. On the replacement claim, the remainder of the patient-pay amount that was not used by the first facility must be entered in F.L. 39 - 41 and the Value Code must be D3. An explanation of the need for the replacement claim must be entered in the Remarks (F.L. 84).

HOSPITAL LEAVE DAYS

Hospital leave days are limited to a total of 10 days per admission to the hospital for emergency medical treatment. When billing, the facility must use Revenue Code 0185 and Occurrence Span Code 74 in F.L. 36, with dates representing the leave days.

THERAPEUTIC LEAVE DAYS

Therapeutic leave days are limited to a total of 18 days during a 365-day period. When billing, the facility must use Revenue Code 0183 and Occurrence Span Code 74 in F.L. 36, with dates representing leave days.

COMPLEX CARE MEMORANDUM OF UNDERSTANDING (MOU)

Complex Care Memorandum of Understanding (MOU) is for services beyond those covered by a normal per diem rate. MOUs require prior authorization. When billing, the facility must enter the nine-digit prior authorization number listed on the Medicaid authorization letter in F.L. 63 on the UB-92. In the event the facility receives a prior authorization number for an MOU and also for therapy services, the prior authorization number for the MOU must be entered in F.L. 63 and the authorization number for the therapy must be entered in F.L. 84, Remarks. The facility must bill with the appropriate daily care accommodation revenue code (e.g., 110, 120). For information on Complex Care MOUs, the provider may call (517) 241-4293.

FACILITY UNDER NEW OWNERSHIP

There may be situations where the facility changes ownership. If this occurs, the facility must obtain a new provider ID Number for the new owner. In this case, the facility must submit separate claims for each provider ID Number. That is, if the facility changes ownership in the middle of the month and the beneficiary was in continuous residency at the facility for the month, the facility must submit a claim using the old provider ID Number for the first part of the month and another claim for the second part of the month using the new provider ID Number. The process mentioned for two facilities and two claims in a month should be followed for beneficiaries with patient–pay amounts.

BENEFICIARY TRANSFER

When a beneficiary is transferred from one facility to another, the MDCH recommends that the second facility obtain the therapeutic leave day record and Medicare status for the year from the first facility. Maintenance of these records will allow the second facility to bill properly and thereby prevent unnecessary rejections.

HOSPITAL SWING BEDS

Providers of Medicaid swing bed services may not bill for swing bed days unless the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid hospital diagnosis related group (DRG) of the admission.

The **Admission Date** on the claim is the date the beneficiary was admitted to the swing bed. A beneficiary may not be admitted to the swing bed until discharged from an acute care bed.

The **From Date** and **Through Date**, F.L. 6 on the claim, are the beginning and end dates of the billing period. No more than one calendar month may be billed on a claim. The billing period for a Medicaid

covered swing bed stay begins when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid hospital DRG for the hospital admission.

Hospitals which are exempt from the DRG system may bill for Medicaid covered swing bed days beginning the day of admission to the swing bed.

The **Number of Days**, F.L. 46 on the claim, is the number of swing bed care days provided. The day of admission to the swing bed may not be included in the billing period. To determine if the admission date is included in the billing period, refer to the instruction for the **From Date** above.

The admission date to the swing bed is not included in the billing period if the admission date to the swing bed is within the Medicare DRG coverage period.

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

ANCILLARY PHYSICAL AND OCCUPATIONAL THERAPY AND SPEECH PATHOLOGY

- Each ancillary service must be billed on a separate claim line. Series billing is not allowed.
- Each claim line requires a date of service.
- Each claim line requires a revenue code and a CPT/HCPCS code.
- Each claim requires a nine-digit prior authorization number in F.L. 63 on the UB-92.

NOTE: In the event the facility receives a prior authorization number for therapies and an authorization number for an MOU, the prior authorization number for the MOU must be entered in F.L. 63 and the authorization number for the therapy must be entered in F.L. 84, Remarks.

OUTPATIENT COUNTY MEDICAL CARE FACILITIES

- When billing for therapies, outpatient county medical care facilities must indicate the Type of Bill as 23X.
- Each service must be billed on a separate claim line. Series billing is not allowed.
- Each claim line requires a revenue code and a CPT/HCPCS code.
- Each claim requires a nine-digit prior authorization number in F.L. 63 on the UB-92.

MEDICARE PART B CO-INSURANCE AND DEDUCTIBLE AMOUNTS

- Each claim line requires a date of service.
- Each claim line requires a revenue code and a CPT/HCPCS code.

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REPLACEMENT CLAIMS

Replacement claims (adjustments) are submitted when all or a portion of the claim was paid incorrectly or a third-party payment was received after MDCH made payment. When replacement claims are received, MDCH deletes the original claim and replaces it with the information from the replacement claim. It is very important to include **all** service lines on the replacement claim, whether they were paid incorrectly or not. All money paid on the first claim will be taken back and payment will be based on information reported on the replacement claim only. Examples of reasons a claim may need to be replaced:

- to return an overpayment.
- to correct information submitted on the original claim.
- to report payment from another source after MDCH paid the claim.
- to correct information that the scanner may have misread.

If the provider needs to do a replacement of a previously paid claim, the provider must indicate in the Type of Bill (Form Locator 4) a **7 (xx7)** as the third digit "frequency"**.**

The provider must enter in Form Locator 37 the 10-digit Claim Reference Number of the last approved claim or adjustment being replaced.

The provider must enter in Form Locator 84 the reason for the replacement.

See Medicaid claim example in the UB-92 Manual.

VOID/CANCEL OF A PRIOR CLAIM

If a claim was paid under the wrong provider or beneficiary ID Number, the provider must void/cancel that claim. To void/cancel the claim, the provider must indicate in the Type of Bill (Form Locator 4) an **8 (xx8) as the third digit "frequency."** The 8 indicates that the bill is an exact duplicate of a previously paid claim, and the provider wants to void/cancel that claim. The provider must enter in Form Locator 37 the 10-digit Claim Reference Number of the last approved claim or adjustment being cancelled **and** enter in Form Locator 84 the reason for the void/cancel. NOTE: A void/cancel claim must be completed exactly as the original claim.

A new claim may then be submitted using the correct provider or beneficiary ID number.

See Medicaid claim example in the UB-92 Manual.

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GENERAL BILLING INFORMATION FOR THIRD-PARTY COVERAGE

Third Party Liability (TPL): Payment resources available from both private and public insurance and other liable third parties that can be applied toward a beneficiary's health care expenses.

Third Party Payer: Any individual, entity, or program that is or may be liable to pay all or part of health care costs incurred by a beneficiary. This includes Medicare, an insurance company, commercial health maintenance organization (HMO), preferred provider organization (PPO), Champus, Workers' Compensation, an indemnity policy, and automobile insurance.

Private health care coverage and accident insurance, including coverage held by or on behalf of a MDCH beneficiary, is considered primary and must be billed according to the rules of the specific plan. The MDCH will not pay for services that would have been covered by the private payer if applicable rules of that private plan had been followed. A beneficiary with more than one level of private coverage must receive care at the highest level available. Providers are expected to take full advantage of the highest other insurance coverage from any third party resource (accept assignment, enrollment, participation).

Insurance carrier billing information is contained in the Carrier ID Listing in the Other Insurance Appendix of this manual.

If the provider does not participate with the commercial insurance carrier, the provider is expected to refer the beneficiary to a participating provider with the commercial coverage. Beneficiaries may obtain a list of participating providers from the insurance carrier. If a participating provider is not available, the provider should contact the TPL area for assistance. Phone 1-800-292-2550 or e-mail TPL_Health@Michigan.gov.

The Medicaid ID Card does contain Medicare and other insurance information, but the most current coverage information made known to MDCH is available from the Department's Eligibility Verification Contractor: 1-888-696-3510. Because coverage points change, it is still the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to provision of the service.

Providers must always identify third-party resources and total third-party payments when submitting a claim to the MDCH. This would include reimbursement from an indemnity policy.

MEDICARE

Nursing facilities are reminded that federal regulations require Medicaid providers to bill all available third-party resources, including Medicare, prior to billing Medicaid.

Medicare Part B Co-insurance and Deductible Amounts

Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, and Nursing Facilities for the Mentally Ill

Medicaid will reimburse nursing facilities, county medical care facilities, hospital long term care units, and nursing facilities for the mentally ill for any Medicare Part B co-insurance and deductible amounts, based on Medicare's payment, up to Medicaid's maximum amount allowed. Also, Medicaid will cover the co-insurance and deductible amounts on any Medicare covered services not normally covered by Medicaid. The Billing Codes Appendix of this manual identifies the revenue codes for the Medicare Part B co-insurance and deductible amounts.

Prior authorization is not required for billing the Medicare deductible and co-insurance amounts. However, if the facility is uncertain of Medicare coverage, prior authorization from Medicaid should still be obtained. This will allow the facility to render the service, bill Medicare, then if appropriate, bill Medicaid for its share of the service.

Services for which Medicare has made a payment may not be used to offset the patient-pay amount. Co-insurance amounts will be charged to the patient-pay amount, and Medicaid will reimburse any applicable difference between the patient-pay amount and co-insurance rate.

If a beneficiary has Medicare Part B coverage and the service(s) is not covered by Medicare, Medicaid considers these services in the routine nursing care.

OTHER INSURANCE

If a Medicaid beneficiary has insurance coverage via a traditional insurance plan, or is enrolled in a commercial health maintenance organization (HMO) or other managed care plan, the rules for coverage by the commercial plan must be followed. The beneficiary must seek care from network providers, and authorization or a referral must be obtained as necessary. If the coverage rules of the commercial plan are not followed, the MDCH is not liable for payment of services denied by the plan for these reasons. Medicaid will only pay for services excluded from plan coverage if they are covered Medicaid services.

Medicaid will pay fixed co-pays, co-insurance and deductibles up to the allowable screen as long as the rules of the commercial coverage plan (point of service, PPO, etc.) are followed. The beneficiary must use the highest level of benefits available to them under the policy. For example, Medicaid will not pay the point of service sanction amount for the beneficiary electing to go out of network.

Providers may enter into agreements with third-party payers to accept payment for less than their usual and customary charges. These arrangements are often called "Preferred Provider" or "Participating Provider Agreements," and are considered payment in full for services rendered. Since the insured has no further liability to pay, MDCH has no liability. The MDCH may only be billed if the third-party payer has determined the insured/beneficiary has a legal obligation to pay.

If payments are made by a commercial insurance, the amount paid, whether it is paid to the provider or the policyholder of the insurance, must be entered in Form Locator 54. If the provider does not accept direct payment from the other insurance, or the other insurance company does not allow direct payment to the provider, it is the provider's responsibility to obtain the money from the policyholder. This could include most types of heath insurance indemnity plans. It is acceptable to bill the policyholder in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the commercial coverage.

If there is court-ordered support and the provider is having trouble collecting other insurance payments sent directly to the absent parent, the provider should contact the Revenue and Reimbursement Division for assistance. Phone 1-800-292-2550 or e-mail TPL@Michigan.gov.

DAILY CARE

Daily care is reimbursed on the basis of reasonable costs for all necessary and proper expenses incurred in providing services to beneficiaries. Costs incurred by the facility that do not relate to patient care are not reimbursed by the Medicaid Program. Allowable and non-allowable costs are those defined in the "Medicare Principles of Reimbursement", contained in Title 42 of the Code of Federal Regulations, Chapter IV, Subchapter B, Part 413, as specifically cited or modified by provisions in Attachment 4.19D of Michigan's State Plan for Medical Assistance. The rate of reimbursement for each facility is calculated from cost information submitted by the facility on annual cost reports or interim cost statements. The Chart of Accounts for Michigan Nursing Homes, established under Public Act 241 23(2) of 1975, was created to provide a uniform procedure for recording operating costs for nursing facilities. A uniform charge structure must be applied to the entire facility population receiving these reimbursable services.

Facilities participating in the Medicaid Program must file an annual cost report utilizing the State's uniform cost reporting formats, policies and procedures to the Budget and Finance Administration, Bureau of Fiscal Review and Reimbursement. All facilities are reimbursed for routine nursing services on the basis of a per diem rate of reimbursement. The rate for hospital swing bed programs is based upon the average nursing facility rate for the previous calendar year. The reimbursement rate is a prospective rate set prior to the facility's rate setting/cost reporting period and is fixed for that period, except in specific situations under the approved State Plan.

The reimbursement rate consists of two components: variable cost (operating costs) and plant cost (capital asset related expenditures, and interest taxes). Each reimbursement component is subject to reimbursement limitations in accordance with the approved State Plan. Medicaid Program reimbursement for covered services is made only after all third-party payments have been applied to the charges.

MEDICAID INTERIM PAYMENTS (MIP)

Medicaid Interim Payment (MIP) program participation is available to on-going providers on a voluntary basis for nursing facilities. The MIP program is a payment mechanism designed to assure a level cash flow to facilities during a set time period. Facilities must make application to the Bureau of Fiscal Review and Reimbursement for participation in the MIP program. With MIP, the facility's average semi-monthly payment is calculated for a calendar quarter. The facility is paid on the first and third Wednesday of each month for the following calendar quarter. The status of the semi-monthly MIP amount is reviewed each quarter and revised accordingly to reflect changes in Medicaid approved claims activity. A new MIP amount, if indicated, is calculated and if determined a material amount of change, paid for the succeeding quarter. An annual MIP reconciliation is calculated 90 days after the end of the facility's fiscal reporting period to determine the difference between the MIP amount paid and the dollar amount of approved claims for the specific period. Gross adjustment payments will pay the facility in the event of an underpayment, or reduce future payments in the event of an overpayment.

For information on MIP, the provider may call the Bureau of Fiscal Review and Reimbursement at (517) 335-5356.

MEDICARE

PROVIDER SPECIFIC PART A CO-INSURANCE RATE FOR NURSING FACILITY CARE

Medicaid co-insurance payments for Part A are the lower of the co-insurance charge or the current maximum co-insurance rate established under the formula stated in the Social Security Act. The facility's total payments from Medicare, Medicaid and other insurance may be up to, but cannot exceed, the amount established by Medicare as reasonable (i.e., the amount allowed by Medicare).

MEDICARE PART B SERVICES

Co-insurance and deductible reimbursement for Medicare Part B services are limited to Medicaid fee screens to assure that the total payment received from Medicare and Medicaid (and other insurance) does not exceed the Medicaid rate for that service.

THERAPY/PATHOLOGY

Facilities must establish accounting procedures to reflect individual cost centers for reimbursable therapy/pathology services. Whether the therapist/pathologist is salaried, under contract, or an independent provider, the facility must record expenses in these cost centers for all expenditures for the therapist/pathologist, supportive personnel, equipment and its maintenance, supplies and other costs attributable to providing such services. The facility will also be required to allocate indirect operating expenses to such cost centers in the annual cost report depending on the activity level of ancillary services provided in the facility.

GENERAL INFORMATION

The MDCH establishes a payment amount for all Revenue Codes and CPT/HCPCS codes in the claims processing system. All other resources, including Medicare, must be billed prior to billing Medicaid. When a payment has been made by another resource, Medicaid payment is determined by comparing its normal payment (or the provider's charge, whichever is less) to the amount paid by the other resource.

NOTE: The HIPAA Final Rule on transactions will require significant changes in both paper and electronic remittance information. MDCH plans to issue additional information in the future to address:

1. the implementation of HIPAA – mandated claim adjustment reason codes to replace the current MDCH proprietary edit explanation codes,

2. the implementation of HIPAA – mandated adjustment reason codes to replace the current MDCH proprietary gross adjustment codes, and

3. the availability of the HIPAA – mandated electronic remittance advice (ANSI ASC X12 835 transaction) to replace the current MDCH proprietary electronic remittance advice.

The remittance advice (RA) shows what action was taken on the provider's claim. It shows the claims processed for payment, new claims that pended, and claims that were rejected. The codes next to each service line explain the action taken. The definitions to the codes are listed in the Explanation Code Appendix of this manual.

The MDCH processes claims and issues checks (warrants) every week unless special provisions for payments are included in your enrollment agreement. An RA is sent with each check to explain the payment made for each claim. If no payment is due, but claims have pended or rejected, an RA will also be issued. If claims are not submitted for the current pay cycle and no action is taken on previously pended claims, or no payment gross adjustments are processed in the pay cycle, an RA is not printed.

NOTE: If the total amount approved for claims on any one RA is less than $5.00, a check is not issued for that pay cycle. Instead, a balance is held until approved claims accumulate to an amount equal to or more than $5.00. Twice a year (usually in June and December) all amounts of less than $5.00 are paid.

If a claim does not appear on an RA within 30 days of submission, a new claim should be submitted. The provider should verify that the provider ID# and beneficiary ID# are correct.

REMITTANCE ADVICE MESSAGES

A message may be printed on the next to the last page of the RA or it may be inserted as a flyer. The messages give current information about policy and payment issues. For example, MDCH sends messages to:

- clarify a billing instruction,
- explain problems in the payment system,
- remind providers of a change in programs,
- announce a delay in payment, or

- notify providers of billing seminars.

REMITTANCE ADVICE (RA) HEADER

The RA header contains the following information:

- Provider ID No. and Provider Type: This is the provider ID# from the provider's claim. The first two digits of the Provider ID# appear in the Provider Type box and the last seven digits appear in the Provider No. box.
- Provider Name: This is from the MDCH provider enrollment record for the provider ID# submitted on the claim.
- Pay Cycle: This is the pay cycle number for this RA.
- Pay Date: This is the date the RA is issued.
- Page No.: Pages of the RA are numbered consecutively.
- Federal Employer ID Number or Social Security Number: This is in small print in the upper right corner and is unlabeled. The number on the provider's claim must match the billing provider ID number on file with the MDCH and it must be a valid number with the Michigan Department of Treasury. MDCH cannot issue a check if there is a discrepancy between the number on file with the MDCH or the Michigan Department of Treasury.

  NOTE: If any of the information is incorrect, the provider must contact the Provider Enrollment Unit at (517) 335-5492 to make changes.

REMITTANCE ADVICE (RA) CLAIM INFORMATION

Claims appear on the RA in alphabetical order by the beneficiary's last name. If there is more than one claim for a beneficiary, they appear in Claim Reference Number (CRN) order under the beneficiary's name.

CLAIM HEADER

- Patient ID Number: Prints the beneficiary's Medicaid ID number that the provider entered on the claim.
- Patient Name: Prints the name associated with the beneficiary's ID number from the Medicaid eligibility file. If the beneficiary's ID number is not entered on the claim or is not valid, zeros are printed and the claim is rejected. These claims print first on the RA.

SERVICE LINE INFORMATION

- Prov. Ref. No.: The left-most 14 characters of the patient account number the provider entered on the claim are printed here.
- Claim Reference Number (CRN): A 10-digit CRN is assigned to each claim. If the claim has more than one service line, the same CRN is assigned to each line. The first four digits of the CRN are the Julian Date the claim was received by MDCH. The fifth through tenth digits are the sequential claim number assigned by the MDCH.

  For example: In CRN 2223112345, 2 is the year 2002, 223 is the Julian day of the year (August 11), and 112345 is the sequence number. The combination of Julian day and sequence makes a unique

number that is assigned to each claim. When asking about a particular claim, the provider must refer to the CRN and Pay Date.

The 10-digit CRN is followed by a two-character input ID (2223223445**-XX).** If a service bureau submitted the claim, this will be the service bureau ID. If the provider submitted a paper claim, this will be a scanner identifier.

- **Line No.:** This identifies the line number where the information was entered on the claim.
- **Invoice Date:** This identifies the date the provider entered on the claim or, if left blank, the date the claim was processed by the system.
- **Service Date:** This identifies the service date entered on the claim line.
- **Diagnosis Code:** This identifies the principal diagnosis entered on the claim.
- **Procedure Code:** This identifies the revenue code entered on the service line.
- **Qty:** This identifies the quantity entered on the service line. If the MDCH changed your quantity, an informational edit will appear in the Explanation Code column.
- **Amount Billed:** This identifies the charge entered on the service line.
- **Amount Approved:** This identifies the amount Medicaid approved for the service line. Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from Medicaid. For example, when other resources made a payment greater than Medicaid's usual payment.
- **Source/Status:** This identifies the source of funding for paid lines and shows the status of unpaid lines. One claim may have several source codes. The status codes for paid lines are:

MA	Medicaid
SMP	State Medical Program
CIR	Cuban/Indochinese Refugee or Repatriate
CO-DED	Medicare patient

  The status codes for unpaid lines are:

REJ	The service line is rejected.
PEND	The service line is pending and is being manually reviewed.

  NOTE: If one service line on the claim is pending, then all service lines have a PEND status.

- **Explanation Codes:** Explanation Codes indicate the reason a service line was rejected or pended. They also give information about service lines and may point out potential problems. A complete listing of explanation codes and the code indicators are found in the Explanation Code Appendix.
- **Invoice Total:** Totals for the Amount Billed and the Amount Approved print here.
- **Insurance Information:** If Medicaid beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g. vision, medical) print below the last service line information.
- **History Editing:** Certain edits compare the information on the claim to previously paid claims. In some cases, information about the previous claim will print on the RA. This information prints directly under the service line to which it relates. The Explanation Code Appendix contains information on history edits.

- **Page Total:** This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two RA pages, the page total will include only the paid lines printed on each RA page.

  NOTE: Amounts for pended service lines and rejected service lines are not included on the page total.

All nursing facilities on the Medicaid Interim Payment (MIP) program have "MIP" PROGRAM printed on the bottom of each page.

GROSS ADJUSTMENTS

Gross adjustments are initiated by MDCH. A gross adjustment may pertain to one or more claims.

MDCH notifies providers, in writing, when an adjustment will be made. The provider should receive the notification before the gross adjustment appears on the remittance advice (RA).

TYPES OF GROSS ADJUSTMENTS

One of the following adjustment codes prints in the Amount Billed column:

- GACR is a Gross Adjustment Credit. This appears when the provider owes MDCH money. The gross adjustment amount is subtracted from the provider's approved claims on the current payroll.
- GADB is a Gross Adjustment Debit. This appears when MDCH owes the provider money. The gross adjustment amount is added to the provider's approved claims on the current payroll.
- GAIR is a Gross Adjustment Internal Revenue. This appears when the provider has returned money to the MDCH by check instead of submitting a replacement claim. It is subtracted from the Year-to-Date (YTD) Payment Total shown on the summary page of the RA.

REMITTANCE ADVICE SUMMARY PAGE

The Summary Page is the last page of the RA and gives totals on all claims for the current payroll and year-to-date totals from previous payrolls.

This Payroll Status: This indicates the total number of claims and the dollar amount for the current payroll. This includes new claims plus your pended claims from previous payrolls that were paid, rejected, or pended on the current payroll.

- **Approved:** This is the number of claims from this payroll with a payment approved for every service line. The dollar amount is the total that the MDCH approved for payment.
- **Edit 504 Pends:** This is the number of claim forms with dates of service that are too old for immediate processing. The dollar amount is the amount the provider billed.
- **All Other Pends:** This is the number of claims from this payroll that are pending. The dollar amount is the total charges billed.
- **Rejected:** This is the number of claim lines from this payroll that were rejected. The dollar amount is the total charges billed.

- **App'd/Rejected:** This is the number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total approved and the amount next to Rejected Claim Lines is the total charge billed.
- **Total Pends in System:** This is the total number of new and unresolved pended claims in the system and total charges.
- **Previous YTD (Year-to-Date) Payment Total:** This is the total amount paid to the provider for the calendar year before any additions or subtractions for this payroll.
- **Payment Amount Approved This Payroll:** This is the total dollar amount approved for this payroll.
- **Actual Payment Due This Payroll To Provider:** This amount is the Payment Amount Approved plus any balance due to the provider and minus any balance owed by the provider to MDCH.
- **Payment Made This Payroll:** This is the amount of the check issued for this payroll.
- **New YTD Payment Total This Payroll:** This is the total payment for the calendar year including payments made on this payroll.
- **Balance Owed or Balance Due:** One or more of the following prints if the provider has a balance owed or a balance due.
    - **Balance Due to Provider by MDCH:** This appears if the payment amount approved is less than $5.00 or a State account is exhausted.
    - **Balance Owed by Provider to MDCH:** This appears when money is owed to MDCH, but the provider does not have enough approved claims from a particular State account (e.g., CC or SMP) to deduct what is owed.
    - **Previous Payment Approved, Not Paid:** This appears if a balance is due from MDCH on the previous payroll.
    - **Previous Payment Owed by Provider to MDCH:** This prints when a balance is due from the provider on a previous payroll.
- **Pay Source Summary:** This identifies the dollar amounts paid to the provider from the designated State accounts.

PENDED AND REJECTED CLAIMS

When claims are initially processed, the Source Status column on the RA identifies which service lines have been paid, rejected or pended. The RA explanation code column lists edits which apply to each service line.

Rejections: If a service line is rejected, an explanation code or codes followed by an R will print in the Explanation Code column of the RA (e.g. 092R). The provider should review the definitions of the codes found in the Explanation Code Appendix to determine the reason for the rejection.

Pends: If any claim line pends for manual review, PEND prints in the Source Status column for all the service lines on the claim. An explanation code or codes, followed by a P (e.g. 936P), will print in the Explanation Code column of the RA. These pended claims will not print again on the RA until:

- the claim is paid or rejected, or
- is pended again for another reason, or
- has pended for 60 days or longer.

Note: After a claim initially pends, it may pend again for a different reason. In that case, a symbol (#) will print in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.

If the MDCH determines that the claim can continue through the claims processing system, the edit will appear with a * (e.g. 936*) on your RA. If the MDCH determines that the service line should be rejected for the reason specified by the pending edit, an additional edit will be added to the service line (e.g. 727R, 936P) and the Source Status code on the line will say REJ.

When a claim is pended, the provider must wait until it is paid or rejected before submitting another claim for the same service.

JULIAN CALENDAR

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

For leap year, one day must be added to number of days after February 28. The next three leap years are 2004, 2008 and 2012.

Example: claim reference # 1351203770-59
1 = year of 2001
351 = Julian date for December 17
203770 = consecutive # of invoice
59 = internal processing

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The MDCH has numerous resources to assist you with billing services to Medicaid.

Michigan Department of Community Health Website: Go to www.michigan.gov/mdch, Providers, Information for Medicaid Providers, where you will find Medicaid-related information including a listing of health plans, a sanctioned provider list, fee screens, procedure code listings, policy bulletins and other relevant Medicaid information.

Electronic Billing Resources: For information on submission of electronic claims using the Michigan Medicaid Interim Institutional Version 4010 (ASC X12N 837) format, see the User's Guide, transaction set, and envelope information documents on the MDCH website at: www.michigan.gov/mdch, Providers, Information for Medicaid Providers, Michigan Medicaid Uniform Billing Project, Electronic Claims Submission Information.

Use the following addresses to submit your questions on electronic billing, request forms to become an authorized billing agent, or to schedule electronic testing of claims. Be sure to include your name, phone number and address with all inquiries.

E-mail: AutomatedBilling@Michigan.Gov

Or write to: Michigan Department of Community Health
Medicaid Automated Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

National Electronic Data Interchange Transaction Set Implementation Guide: Go to www.wpc-edi.com/hipaa/hipaa_40.asp. (NOTE: There is an underscore_between hipaa and 40.asp)

Provider Inquiry: Direct questions on program coverages, claim completion instructions, and information printed on the remittance advice (RA) to:

1-800-292-2550

Review the information in the manual pertaining to the policy or procedure before you call. Have your Medicaid provider ID number, the claim information and the RA (if applicable) when you call. Ask for the telephone representative's name so you can speak to the same person if a follow-up call is necessary.

Written Requests: You may e-mail questions or send them hard copy by mail. Include your name, phone number, provider ID #, beneficiary name and ID#, CRN and pay cycle as appropriate. Include a clear, concise statement of the problem or question.

E-mail: ProviderSupport@Michigan.Gov

Or write to: Michigan Department of Community Health
Research and Analysis
P. O. Box 30479
Lansing, MI 48909 - 7979

Provider Training Sessions: (517) 335-5149. MDCH staff conducts provider-training sessions throughout the state targeted to specific provider groups. Receive information on schedules, training session content, and reservations.

TPL (Third Party Liability) Help: Staff resolves calls regarding other insurance additions and terminations, billing problems involving other insurance, and disenrollment from health plans when there is commercial HMO coverage.

☎ 1-800-292-2550

E-mail: TPL_Health@Michigan.Gov

Provider Enrollment Help: ☎ (517) 335-5492. Requests for enrollment applications or questions about current enrollment, and all change of ownership, change of address, or change in federal tax employer ID numbers or social security numbers should be directed here.

Manuals: ☎ (517) 335-5158 for information on ordering provider manuals. This manual and other Medicaid publications are available at a nominal cost from MDCH.

Miscellaneous Transactions Unit (MTU): ☎ (517) 335-5477 to get information on submitting out-of-state or non-enrolled provider claims.

Eligibility Verification Contractor: ☎ 1-888-696-3510 to determine a beneficiary's eligibility status, health plan enrollment status, and other insurance coverage.

OCCUPATIONAL/PHYSICAL THERAPY-SPEECH PATHOLOGY PRIOR APPROVAL-REQUEST/AUTHORIZATION (MSA-115)

As indicated in Chapter III, speech pathology, occupational therapy, and non-routine physical therapy require prior authorization from the Review and Evaluation Division each calendar month(s) of service being requested. Initial evaluations do not require prior authorization.

INITIAL REQUEST

When making the initial request for prior authorization of therapy, the facility must attach a copy of the initial evaluation and the written treatment plan.

The initial evaluation and treatment plan must include the following information:

- statement of the problem (i.e., the specific physical entity and functional incapacity involved or the specific speech and/or language diagnosis based upon results of formal/informal testing);
- baseline condition at initial evaluation, measured in units appropriate to the problem (for speech pathology this would include the baseline description of clinical and functional performance in all language modalities);
- short-term goals appropriate to the beneficiary's diagnosis, level of severity, prognosis, and functional needs;
- proposed technique for reaching goals, including the planned progression from the baseline condition to the goal; and
- method by which progress will be measured.

This and any other supplemental documentation must include the beneficiary's name and Medicaid ID Number, the date, and the facility's name and ID Number.

The MSA–115 is used to obtain authorization for therapy **prior to the provision of the service.**

CONTINUED REQUEST

Authorization of the initial service does not guarantee authorization of continued service. The therapist must submit the MSA-115 for continued therapy with documentation of the most recent progress. The progress notes must be concise and refer to the baseline established in the initial evaluation. Progress must be objective and measurable.

DISTRIBUTION OF FORM

The prior authorization form is a four-part, snap-out form. The request for prior authorization must be complete and of adequate clarity to allow the Michigan Department of Community Health (MDCH) Consultant to determine the appropriateness of the service without examining the beneficiary.

The original, first, and second copies of the form must be submitted to:

Michigan Department of Community Health
Review & Evaluation Division
Prior Authorization & Review Section
P.O. Box 30170
Lansing, MI 48909 - 7670

The facility should retain the third copy for its records until the approved or disapproved form is returned by the MDCH. If the facility does not receive a response regarding the original prior authorization form after 15 days of the date of its submission, a new request should be submitted. (The reason a second prior authorization form is being submitted should be included [i.e., no response to the first request].) The facility must not bill until authorization is received and the services are rendered.

PROCESS

The MDCH Consultant will make a determination and assign a Prior Authorization Number to approved requests. The original will be returned to the facility. If a portion of the request is denied, only the services authorized will be reimbursed by the Medicaid Program. The nine-digit Prior Authorization Number must be entered in F.L. 63 on the UB-92 claim when billing. The facility must retain a copy of the approved request as part of the beneficiary's medical record.

Approval of the request confirms that a beneficiary is in need of services which can be covered by the Program. It does **not** verify beneficiary eligibility, level of care, nor guarantee the fee charged. The facility is responsible for **verifying** the beneficiary's Medicaid eligibility prior to providing the service.

Whenever a beneficiary is admitted to the facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request. In order to assure continuity of the treatment regimen in such instances, retroactive authorization may be requested if the request is filed within ten days following admission. Retroactive authorization may be granted when the service is rendered within Program guidelines for coverage (e.g., is restorative in nature).

Facilities participating in Medicare are not required to obtain prior authorization for the deductible and/or co-insurance amounts when the services are approved by Medicare.

BILLING

The Invoice Processing System is programmed to match the services authorized with the services billed. The services billed must not exceed the services authorized.

COMPLETION INSTRUCTIONS

The following instructions pertain to the completion of the MSA-115. All prior authorization forms must be typewritten to facilitate processing the forms.

Item 1
Control Number

The **control number** is used by the MDCH for identification purposes. The facility must **NOT** mark in this item.

Item 2 through Item 4
Consultant's Use Only

These items are for the MDCH **Consultant's use only.** These items are not to be completed by the facility.

Item 5
Prior Authorization Number

The consultant will enter a **nine-digit Prior Authorization Number** in this item if all or part of the service is authorized. The facility must enter this number in F.L. 63 on the UB-92 claim in the appropriate item when submitting the charges for payment.

NOTE: In the event the facility receives a prior authorization number for therapies and an authorization number for an MOU, the prior authorization number for the MOU must be entered in F.L. 63 and the authorization number for the therapy must be entered in F.L. 84, Remarks.

If the service is disapproved, no number will be assigned.

Item 6 through Item 8
Facility Identification Data

The **facility's name, provider type code, and seven-digit identification number** are used to identify the provider. They must be entered as they appear on the Medical Assistance Provider Enrollment Turn-around Form, page 2.

Item 9
Facility Reference Number

The facility may enter a **reference number or the beneficiary's name**, not to exceed 10 alpha and/or numeric characters, to comply with its individual filing system.

Item 10 through Item 11
Facility Identification Data

The facility's **mailing address** (including an attention line if appropriate) **and telephone number** (including area code) assist the Consultant in resolving inquiries and returning the prior authorization form to the facility.

Item 12 through Item 15
Client Identification Data

The **beneficiary's name** (last, first, and middle initial), **sex** (M or F), **ID Number, and birth date** (in the six-digit format: month, day, year) identify the beneficiary. These items must be entered exactly as they appear on the Medical Assistance Authorization (Medicaid ID Card).

Item 16
Admission Date

This is the date the beneficiary was **most recently admitted** to the facility.

Item 17 through Item 18
Diagnosis and Onset Date

The **diagnosis** for which the beneficiary requires the requested services and the **onset date of the diagnosis** indicate the primary reason the beneficiary requires the requested services.

If the beneficiary has a chronic disease (e.g., arthritis) and recently suffered an exacerbation, the approximate date of such exacerbation must be cited.

Item 19 through Item 21
Therapist Identification Data

The **therapist's/pathologist's name, office telephone number** (including area code), **address**, and **certificate number** identify the therapist/pathologist. (Speech pathologists must attach a copy of the Certificate of Clinical Competency or Letter of Equivalency to the first prior authorization involving an individual speech pathologist.)

The therapist/pathologist wishing to add any remarks or comments may do so by attaching a separate sheet which must contain the beneficiary's name and identification number, date, and the facility's name and identification number.

Item 22
Treatment Authorization Request

The **Treatment Authorization Request** must be checked to indicate whether this is the initial prior authorization request for this beneficiary for this treatment plan, a continuing request for an additional calendar month of service, or a revision of a previously authorized treatment plan.

Item 23
Service Given By

This indicates **who is to provide the service**: therapist/ pathologist, assistant, or aide (this does not refer to a nurse's aide).

Item 24
Treatment Month

The **calendar month(s) in which treatment is to be rendered** must be shown in a two-digit format (e.g., April should be shown as 04).

Item 25
Date Started

The **date treatment was started** for the given diagnosis must be entered.

Item 26
Last Authorized

The **date the MDCH Consultant signed the last approved prior authorization request** for the given diagnosis must be entered.

Item 27
Number Sessions

This is the number of **sessions rendered up to the date the form was completed** for the given diagnosis. The facility must not indicate the number of sessions previously authorized for a different diagnosis.

Item 28
Rehabilitation Potential

This is a brief assessment of the beneficiary's **rehabilitative potential** and factors that contribute to this determination (e.g., "good potential, patient's attitude is positive and persistent, progress depends upon the reduction of pain").

Item 29
Line Number

The **line number** is to be used as a reference. **NOTE:** A separate Line Number must be used for each different CPT/HCPCS Code that is used.

Item 30
Number per Month

This is the **number of times** the service is to be provided. Services may be prior authorized on a weekly basis.

Item 31
Procedure Code

This is the CPT/HCPCS code(s) as listed in the Billing Code Appendix , which describes the service(s). **NOTE:** For each different CPT/HCPCS code a separate Line Number must be used.

Item 32
Consultant Use Only

The facility is not to complete this item. The **MDCH Consultant** will use this area to indicate any amendments on approved services. The facility should always review this area to see if any changes are necessary for delivery of services and/or accurate billing.

Item 33
Goals

The **expectations** for the beneficiary's ultimate achievement and the **length of time** it will take must be stated (e.g., ambulation unassisted for 20 feet, able to dress self within 15 minutes, oral expression using 4-5 word phrases to express daily need).

Item 34
Progress Note/Discharge Plan

This is the documentation of the beneficiary's **progress** from the prior month to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of

beneficiary nursing and family education may be included. The final month of anticipated treatment should include the **discharge plan** for the carry-over of achieved goals to supportive personnel.

Item 35
Complications Causing Extension of Treatment

Any **condition or complication that might require an extension of services** (e.g., decubiti, urological complications, or fractures) should be fully described.

Item 36
Physician Certification

The **attending physician** must indicate if this is an **initial certification or a recertification** and **sign** and **date** the prior authorization form. The attending physician's signature is required each time a request is made.

Item 37
Provider Certification

The facility's **certification** is required to validate the form. This is accomplished by the facility's authorized representative's **signature** on the form and the form must be **dated**. All unsigned requests will be returned to the facility for signature.

Item 38 through Item 43
Consultant Use Only

These items will be **completed** by the consultant. The consultant will indicate that the service is approved as presented, approved as amended, or disapproved. If all or part of the plan is authorized, the consultant will assign a nine-digit Prior Authorization Number in Item 5.

The therapist/speech pathologist must keep progress notes. Such notes include the:

- date of treatment,
- name of the individual who rendered treatment,
- type and length of treatment, and
- beneficiary's response to the treatment.

The progress notes must be included in the beneficiary's medical record.

The cost of supplies and equipment (e.g., plate guards) used as part of the therapy/speech pathology program is included in the reimbursement for the therapy/speech pathology.

Exhibit IV-I illustrates the Occupational/Physical Therapy-Speech Pathology Prior Approval-Request/Authorization as it might be completed in a usual situation.

EXHIBIT IV-I

OCCUPATIONAL/PHYSICAL THERAPY - SPEECH PATHOLOGY
PRIOR APPROVAL - REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

1. CONTROL NUMBER

NOTE: FOR INITIAL AND REVISED REPORTS ONLY, YOU MUST ATTACH COPY OF INITIAL EVALUATION AND TREATMENT PLAN.

CONSULTANT USE ONLY 2. 3. 4.

5. PRIOR AUTHORIZATION NUMBER

6. TREATMENT SITE	7. TYPE	8. I.D. NUMBER	9. PROVIDER'S USE ONLY
Hills Nursing Home	60	6143500	Good

10. ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)	11. PHONE NUMBER
5 Main Street, Ada, Michigan 49441	(616) 243-9170

12. RECIPIENT NAME (LAST, FIRST, MIDDLE INITIAL)	13. SEX	14. I.D. NUMBER	15. BIRTHDATE	16. ADM. DATE
Good, Sam	M	11000047	04-01-37	02/01/02

17. DIAGNOSIS TO BE TREATED/EVALUATED	18. ONSET DATE
CVA with resultant left hemiparesis	

19. THERAPIST/PATHOLOGIST NAME (LAST, FIRST, MIDDLE INITIAL)	20. OFFICE PHONE NUMBER	21. LICENSE/CERTIFICATION NUMBER
O'Malley, Sue R.	(616) 432-7610	843714

22. TREATMENT AUTHORIZATION REQUEST	23. SERVICE GIVEN BY	24. TREATMT. MO.	25. DATE STARTED	26. LAST AUTH.	27. NO. SESSIONS
☐ INITIAL ☐ CONTINUING ☒ REVISED	☒ THERAPIST/ PATHOLOGIST ☐ ASST. ☐ AIDE	08	12/01/02	11/24/02	1

28. REHABILITATION POTENTIAL

33. GOALS

Gait Training

ESTIMATED TIME 2 months

29. LINE NO.	30. NUMBER PER MONTH	31. PROCEDURE CODE	32. CONSULTANT USE ONLY
01	20	97116	
02			
03			
04			
05			
06			

34. PROGRESS NOTE/DISCHARGE PLAN

Patient is exhibiting some hesitation in moving outside the Parallel bars. Does two lengths with stand-by assistance Before rest. Trying to get outside of bars within next week.

35. COMPLICATIONS CAUSING EXTENSION OF TREATMENT

36. PHYSICIAN CERTIFICATION

I certify _____, re-certify X that I have examined the patient and determined that therapy is necessary; that service will be furnished on an in/out-patient basis while the patient is under my care; that I approve the above treatment plan or evaluation and will review it every 30 days or more often if the patient's condition requires.

James P. Pike, M.D.	James P. Pike, M.D.	01/03/02
PHYSICIAN NAME (TYPE OR PRINT)	PHYSICIAN SIGNATURE	DATE

37. PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understand the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

Peta Reese	08/03/02
PROVIDER SIGNATURE	DATE

CONSULTANT USE ONLY

38. CONSULTANT REMARKS

39. APPROVED AS	40. DISAPPROVED	41. CONSULTANT SIGNATURE	42. DATE	43. MONTH
PRESENTED ☐ AMENDED ☐	☐			

MSA-115 (Rev. 9-96) Previous edition may be used.

MAIL TO MDCH/MSA

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DAILY CARE

The following providers may bill for daily care and must enter the appropriate revenue code that identifies the specific daily care accommodation being billed:

Nursing Home Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Units (Provider Type 63)
Nursing Facilities for the Mentally Ill (Provider Type 72)

The UB-92 Manual provides the revenue codes to be used for Michigan Medicaid.

ANCILLARY SERVICES

Ancillary services that may be billed to Medicaid are listed below. The revenue codes that must be used are also listed. Also included are the providers allowed to bill for the particular services.

PHYSICAL/OCCUPATIONAL THERAPY AND SPEECH PATHOLOGY

The following providers may bill physical/occupational therapy and speech pathology:

Nursing Home Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Nursing Facilities for the Mentally Ill (Provider Type 72)
Outpatient County Medical Care Facilities (Provider Type 64)

When billing on the UB-92 claim form, the facility must use the following codes. The Revenue Codes are located in the UB-92 Manual. The CPT Codes are located in the Physicians' Current Procedural Terminology coding manual. The HCPCS Codes are located in the Health Care Financing Administration Common Procedure Coding System manual.

DESCRIPTION	REVENUE CODES	CPT/HCPCS
Physical Therapy	0420, 0424, 0429	97001, 97002, 97012, 97014, 97016, 97018, 97020, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97116, 97124, 97139, 97140, 97520, 97530, 97799

DESCRIPTION	REVENUE CODES	CPT/HCPCS
Occupational Therapy	0430, 0434, 0439	97003, 97004, 95851, 95852, 97016, 97018, 97022, 97034, 97035, 97110, 97112, 97124, 97530, 97799
Speech Pathology	0440, 0443, 0444, 0449	92506, 92507, 92508 92526, 92597, G0195 (HCPCS)

OTHER SERVICE REVENUE CODES

The following providers may bill the following services as indicated.

County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)

0250 Pharmacy – Covered when billed by a hospital long term care unit.

0410 Oxygen (gas, equipment, and supplies) –Covered when billed by a county medical care facility or hospital long term care unit.

Medicare/Medicaid – If *Medicare* is being billed for the nursing facility stay, neither the nursing facility nor a medical supplier can bill Medicaid for oxygen services (i.e., gas, equipment, supplies). Oxygen services are included in the Medicare payment to the facility under Medicare's Prospective Payment System.

MEDICARE PART B CO-INSURANCE AND DEDUCTIBLE AMOUNTS

The following providers are allowed to bill Medicaid for Medicare Part B co-insurance and deductible.

Nursing Home Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Nursing Facilities for the Mentally Ill (Provider Type 72)

For the following revenue codes, Medicaid will reimburse for any Medicare Part B co-insurance and deductible amounts, based on Medicare's payment, up to Medicaid's maximum amount allowed. Also, Medicaid will cover the co-insurance and deductible amounts on any Medicare covered services not normally covered by Medicaid. When billing, each claim line also requires a CPT/HCPCS code.

If a beneficiary has Medicare Part B coverage and the service(s) is not covered by Medicare, Medicaid considers these services in the routine nursing care.

Revenue Codes

0270, 0272, 0274, 0275, 0276, 0301 – 0359, 0400 – 0409, 0420 – 0449, 0460, 0469, 0480 – 0489, 0610 – 0619, 0636, 0730 – 0749, 0800 – 0809, 0920 – 0929, and 0940 – 0949.