MSA
MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 10-58

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

Hospice, and

Home Health Agencies

Issued: December 1, 2010

Subject: Billing Long Term Care Insurance, and

Reporting National Uniform Billing Committee (NUBC) Value Codes 22 and 66

Effective: As Indicated

Programs Affected: Medicaid

THIS BULLETIN MUST BE SHARED WITH THE PROVIDER'S BILLING DEPARTMENT. THIS BULLETIN DISCUSSES THE BILLING OF LONG-TERM CARE INSURANCE AND THE REPORTING OF VALUE CODES 22 AND 66.

Billing Long-Term Care Insurance

The Coordination of Benefits Chapter in the Medicaid Provider Manual states that federal regulations require all identifiable resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a Medicaid beneficiary has *long-term care insurance*, it is recognized as other insurance and that resource must be exhausted prior to billing Medicaid.

To assure that long-term care insurance is exhausted prior to billing Medicaid, if the facility receives direct reimbursement from the long-term care insurance company, the provider should not release a billing statement to the beneficiary or beneficiary's representative. Doing so may jeopardize payment to the provider with payment going to the beneficiary instead.

Release of a billing statement may enable payment to go directly to the beneficiary and not the provider of service.

Providers are reminded that all records are of a confidential nature and should not be released to anyone other than a beneficiary or a beneficiary representative unless a release is signed by the beneficiary or disclosure is permitted under all applicable confidentiality laws.

If the provider determines that a beneficiary has a long-term care insurance policy but it is not reflected on the mihealth card or the Community Health Automated Medicaid Processing System (CHAMPS) Eligibility Inquiry, the provider must report the policy to the beneficiary's case worker at the Department of Human Services (DHS).

NOTE:
The following NUBC Value Codes are not properly deducting from claims. These errors should be resolved by 2011. All claims will be adjudicated at that time.

Reporting NUBC Value Codes 22 and 66

- ✓ NUBC Value Code 22 – Surplus

  Review of Medicaid claims indicate that providers are using this value code to report monies received from the beneficiary's family (e.g., selling of beneficiary's home) and the money would put the beneficiary over assets for Medicaid eligibility for the month.

  The provider must report these monies on the claim AND report these monies to the beneficiary's case worker at DHS.

- ✓ NUBC Value Code 66 – Medicaid Spend Down Amount

  Review of Medicaid claims indicate that some providers are not reporting this code as required because the spend down amount is not deducting from the claim. Providers are still to report Value Code 66. As noted above, claims will be adjudicated. Providers are not to report NUBC Value Code D3 – Patient Estimated Responsibility "Patient-Pay Amount" instead – which is deducting from the claim.

Manual Maintenance

While this bulletin is a reminder, the provider may retain for future reference.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
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