Inpatient Hospital Q&A

Questions compiled from the Inpatient Hospital Overview Presentation Webinar held August 17, 2021.

Q: How long does Medicaid have for processing claims after the Predictive Modeling records have been received? Actual days or business days?

A: A claim suspended for Predictive Modeling review may suspend up to 120 days or longer depending on the scenario. Providers are encouraged to review the Predictive Modeling Provider Tip.

Q: What is the typical timeframe for coordination of benefit (COB) claims to be processed?

A: COB suspended claims generally process within 60 days. A provider alert was issued on November 26, 2019 referencing delays for claims suspending for other insurance review (CARC 22).

Q: If duplicate records for predictive modeling are uploaded after the first set is approved will the claim take longer to process?

A: Once predictive modeling documentation has been uploaded, providers should receive a letter stating that the documentation has been received. Providers are encouraged to review the Predictive Modeling Provider Tip and wait for the claim to be processed after receiving the confirmation letter prior to submitting another claim for the same services.

Q: What is the difference between Fee for Service (FFS) and other types of Medicaid coverage?

A: Fee-for-service is the term for Medicaid paid services that are not provided through a health plan. If CHAMPS indicates the beneficiary has MA-MC, this means they are enrolled in a Managed Care Health Plan. Please see the link for the Benefit Plan & Service Type Codes Table for explanations and descriptions of each benefit plan.

Q: When Medicaid is the secondary payer to other insurance such as Medicare, do we need to split our billing by month? Medicare does not require a split by month, and we always seem to get denied when we bill the same as Medicare.

A: For inpatient claims providers need to bill all services on one claim, providers do not need to split bill the claims month by month. Providers with additional questions can contact Provider Support.

Q: How long does it take for a newborn to gain Medicaid coverage while in ICU? Will claims before coverage be denied?

A: MDHHS has an automated system in place where once the newborn information has been sent to and updated in Vital Records (the Michigan Birth Registry), the system will look for a match to the mother on our enrollment files. Next, it will run a process to attempt to create the newborn's Beneficiary ID #, add a Medicaid benefit plan and add the baby to the Mother's Health plan. The automated process takes anywhere from 30 to 45 days. Any delay made by the hospitals in reporting their new births to Vital Records will delay the process. Additional details can be found within the Newborn Coverage Tip.

Q: When there is a large volume of medical records for a patient does Predictive Modeling want all the records or certain records to be uploaded to the Document Management Portal (DMP)?

A: The Predictive Modeling letter indicates what type of documentation is required. Review Predictive Modeling Provider Tip for additional information.

Q: Where can I locate which 3M APR-DRG that MDHHS used to process the claim?

A: The 3M APR-DRG that is set on the claim after adjudication is located at the header level of the claim. CHAMPS claim inquiry instructions can be found at this link under the Quick Reference Guides section: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448_78460-471918--,00.html

Q: Where can I locate Listserv instructions?

A: As a means of promoting better service to and improving communications with Medicaid-enrolled providers and individuals who may be interested in the Michigan Medicaid Program, MDHHS offers an electronic, subscription-based e-mail notification service (listserv). This system notifies subscribers of important news relative to the Michigan Medicaid Program, i.e., changes to Medicaid policy, billing issues, training opportunities, etc. Listserv instructions can be accessed using the following link https://www.michigan.gov/documents/LISTSERV_127789_7.pdf.

Q: When billing a claim as a partial inpatient, do we bill with all charges or just the charges for the active days? For instance, the patient is admitted 3/01/21-4/10/21, the patient's Medicaid coverage starts 4/01/21. I know we change the statement dates and add remarks, but just need clarification on if all charges are billed or just charges for 4/01/21-4/10/21?

A: According to the Michigan Medicaid provider manual providers can only bill for the Medicaid eligible days https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-87572--,00.html:

6.2.F. LOSS/GAIN MEDICAID ELIGIBILITY

Under the DRG system, hospitals must wait until a beneficiary is discharged and then bill all services on one claim. Hospitals generally cannot split bill DRG claims. If a beneficiary loses or gains Medicaid eligibility during a hospital stay, the hospital must bill only for the Medicaid eligible days as follows:

- The "from" and "through" dates must reflect only the days of Medicaid eligibility.
- The patient status code must reflect the actual status of the entire admission.
- The remarks section must indicate that the beneficiary was Medicaid eligible for a portion of the hospital stay.
- The admission date must reflect the date the order to admit the beneficiary was written.

When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the inpatient hospital claim.

Q: When we rebill with service line billing, does MDHHS require the primary explanation of benefits (EOB) be uploaded to the Document Management Portal (DMP) each time, or only if the claim is over the year timely filing limitation?

A: For Inpatient claims the other payer information only needs to be reported at the claim header level. The other payer information needs to be reported with the appropriate CARC codes; an EOB uploaded to the DMP is not required.

Q: Can you remind us of where we can address additional questions via email to provider support?

A: Additional questions can be emailed to ProviderSupport@Michigan.gov or by phone at 1-800-292-2550 Monday through Friday 8:00 am to 5:00 pm EST. Closed on all State of Michigan and major holidays.

Q: I am new to cost reporting and in our records from prior years I'm seeing reports listing Hospital MACI-HMP and LTC HMP specific payments and days. Where would I go to find these reports?

A: Cost reports are available within the Facility Settlement subsystem of CHAMPS. The data can be gathered using the CHAMPS claim reports (either in archived documents for FD622 reports and Remittance Advices RAs or Facility Settlement Archived Documents for weekly and annual claim reports) and look for the benefit plan that will identify the Healthy Michigan Plan (HMP) population. MACI payments are paid by gross adjustment only, and those can be identified with the fund source (HY###) to identify HMP.

Q: Does Medicaid cover an inpatient hospital stay when a patient is incarcerated or in a forensic center? Should CHAMPS eligibility reflect incarcerated?

A: If the beneficiary is incarcerated the eligibility information should reflect that they are incarcerated. The incarceration benefit plan would only cover off-site inpatient hospital stays. Incarceration Benefit Plan Billing.

Q: If a patient is inpatient for only one day and has a short stay qualifying diagnosis, but has a discharge status that would qualify as a transfer, would the claim process as a short stay or a transfer?

A: According to MSA 15-17, an inpatient hospital claim will qualify for the Short Hospital Stay reimbursement if all the following criteria are met:

- The primary diagnosis code billed on the inpatient claim is listed in the diagnosis table below.
- The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim.
- The claim has a date of discharge equal to or one day greater than the date of admission.
- The claim does not include cardiac catheterization lab revenue code 481.
- The claim must include discharge status codes 01, 06, 09, 21, 30, 50, or 51.

Q: If the patient qualifies for short stay status but their discharge status is against medical advice (AMA) would this be payable as an inpatient?

A: According to MSA 15-17. The Short Hospital Stay logic will not apply to inpatient or outpatient claims with the following conditions:

- Claims where Medicaid is the secondary payer. MDHHS will follow the rules of the primary payer, and MDHHS will be responsible for payment up to co-insurance and/or deductible.
- Claims for patients who leave the hospital Against Medical Advice (AMA).
- Claims for deceased patients.
- Claims that include primary diagnoses that are not on the table listed below, including claims for births and deliveries, for example.

Q: For new policy coverages, are there common denials? Or are these the same as the denials presented today?

A: At the time of the presentation, the top 5 suspend and denial reasons were discussed. Additional claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) can be reviewed on the Washington Publishing Company website for the definition of each of the CARCs and RARCs.

Resources

- August 17, 2021: Inpatient Hospital Overview- PDF, Webinar
- CHAMPS Resources: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448_78460---,00.html
- Inpatient Hospital Specific Resources: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448_78458-476276--,00.html
- Medicaid Provider Alerts: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448_78458---,00.html
- Medicaid Provider Manual: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-87572--,00.html
- Predictive Modeling Provider Tip
- Provider Support
    - Phone: 1-800-292-2550
    - Email: ProviderSupport@Michigan.gov
    - Webpage: www.Michigan.gov/MedicaidProviders