# Bulletin

Michigan Department of Community Health

**Distribution:** Hospital 03-09
Home Health Agencies 03-06
Private Duty Nursing Agencies
Hospice 03-02
Nursing Facilities 03-07

**Issued:** August 1, 2003

**Subject:** New Institutional Billing and Reimbursement Chapter

**Effective:** October 1, 2003

**Programs Affected:** Medicaid and Children's Special Health Care Services, State Medical Plan

Attached to this bulletin is a new Billing and Reimbursement Chapter (Chapter IV) for all Medicaid Institutional providers (nursing facilities, home health agencies, hospice providers, hospitals, and private duty nursing agencies). The policies and instructions contained in the chapter are effective for dates of service on or after October 1, 2003.

Also attached to the bulletin is a newly developed list of documentation requirements for institutional providers. At this time, the list only provides information regarding services for which documentation is always required. As the Department continues the review of its claims processing edits, the list will be updated to include situational documentation requirements. The most current version of the list will be maintained on the MDCH website at www.michigan.gov/mdch , click on "Providers", "Information for Medicaid Providers", then "Medicaid Fee Screens".

**Manual Maintenance**

- On 10/1/03 replace your current Chapter IV (Billing & Reimbursement) with the attached Chapter.
- The following bulletins are being obsoleted and should be removed from your manual effective 10/1/03. **Note:** Not all the listed bulletins may apply to your provider type, and may not appear in your manual.

  AP 00-09, AP 00-10, HHA 01-06, Hospice 02-01, Hospital 00-06, MSA 93-14, MSA 97-04, MSA 97-17, MSA 00-09, MSA 00-10, MSA 01-14, MSA 01-15, MSA 03-03.

- You may retain the attached list of documentation requirements for future reference, however the most current version of the list will be maintained on the MDCH website.
- This bulletin may be discarded when manual maintenance is completed.

**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 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.

**Approval**

Paul Reinhart, Director
Medical Services Administration

# MDCH INSTITUTIONAL CLAIM DOCUMENTATION REQUIREMENTS

This list contains the most common CPT/HCPCS, Revenue Codes, and ICD-9-CM Procedure Codes that require documentation. This list is not all-inclusive and is subject to update. A current listing of documentation requirements is maintained on the MDCH website.

| CPT/HCPCS Proc Code | Revenue Code | ICD-9-CM Proc Code | Description | Documentation Required |
|---|---|---|---|---|
| | 000220 | | SPECIAL CHARGES/WEIGHT REDUCTI | OP report |
| | 000814 | | UNSUCCESSFUL SEARCH | Bone Marrow Donor Search, attach PA |
| 36415 | | | ROUTINE VENIPUNCTURE-SPEC COLL | Remarks must explain why the Lab doing the tests can't draw the blood, Why is separate procedure is being performed? |
| 55250 | | | VASECTOMY, UNILATERAL OR BILA | Consent |
| 55450 | | | LIGATION (PERCUTANEOUS) OF VA | Consent |
| 74445 | | | CORPORA CAVERNOSOGRAPHY; SUPE | ER Report |
| 76390 | | | MR SPECTROSCOPY | Radiology Report |
| 76496 | | | FLOROSCOPIC PROCEDURE | Radiology Report |
| 76497 | | | CT PROCEDURE | Radiology Report |
| 76498 | | | MRI PROCEDURE | Radiology Report |
| 78455 | | | VENOUS THROMBOSIS STUDY (EG, | Radiology Report |
| 78990 | | | PROVISION OF DIAGNOSTIC RADIOPHARMACEUTICAL(S) | Complete NDC# (11 digits), Dosage, & Name of Product |
| 79900 | | | PROVISION OF THERAPEUTIC RADIOPHARMACUTICAL(S) | Complete NDC# (11 digits), Dosage, & Name of Product |
| 86609 | | | ANTIBODY; BACTERIUM, NE | Documentation or Remarks if specific |
| 86671 | | | ANTIBODY;FUNGUS,NES | Documentation or Remarks if specific |
| 86682 | | | ANTIBODY;HELMINTH,NES | Documentation or Remarks if specific |
| 86753 | | | ANTIBODY;PROTOZOA,NES | Documentation or Remarks if specific |
| 86790 | | | ANTIBODY;VIRUS,NES | Documentation or Remarks if specific |
| 88372 | | | PROTEIN ANAL.OF TISSUE,BAND ID | Pathology Report |
| 92312 | | | CORNEAL LENS FOR APHAKIA-BOTH | Remarks |
| 92313 | | | CORNEOSCLERAL LENS | Remarks |
| 92700 | | | Ent procedure/service | OP Report |
| 94799 | | | UNLISTED PULMONARY SERVICE OR | OP Report |

## MDCH INSTITUTIONAL CLAIM DOCUMENTATION REQUIREMENTS

| CPT/HCPCS Proc Code | Revenue Code | ICD-9-CM Proc Code | Description | Documentation Required |
|---|---|---|---|---|
| A4643 | | | SUPP ADD HI DOSE CONTRAST MRI | Complete NDC# (11 digits), Dosage, & Name of Product |
| A4644 | | | SUPPLY OF LOW OSMOLAR CONTRAST | Complete NDC# (11 digits), Dosage, & Name of Product |
| A4645 | | | SUPPLY OF LOW OSMOLAR CONTRAST | Complete NDC# (11 digits), Dosage, & Name of Product |
| A4646 | | | SUPPLY OF LOW OSMOLAR CONTRAST | Complete NDC# (11 digits), Dosage, & Name of Product |
| A4647 | | | SUPPLY PARAMAGNETIC CONTRAST | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9512 | | | Technetiumtc99mpertechnetate | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9513 | | | Technetium tc-99m mebrofenin | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9514 | | | Technetiumtc99mpyrophosphate | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9515 | | | Technetium tc-99m pentetate | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9516 | | | I-123 sodium iodide capsule | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9517 | | | I-131 sodium iodide capsule | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9518 | | | I-131 sodium iodide solution | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9519 | | | Technetiumtc-99mmacroag albu | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9520 | | | Technetiumtc-99m sulfur clld | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9521 | | | Technetiumtc-99m exametazine | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9522 | | | Indium111ibritumomabtiuxetan | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9523 | | | Yttrium90ibritumomabtiuxetan | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9524 | | | Iodinated I-131 serumalbumin | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9603 | | | I-131sodiumiodidecap per mci | Complete NDC# (11 digits), Dosage, & Name of Product |
| A9699 | | | NOC THERAPEUTIC RADIOPHARM | Complete NDC# (11 digits), Dosage, & Name of Product |
| D7210 | | | SURGICAL REMOVAL ERUPTED TOOTH | Complete description of service |
| D7220 | | | REMOVAL IMPACTED SOFT TISSUE | Complete description of service |
| D7230 | | | REMOVAL PARTIAL BONY IMPACTION | Complete description of service |
| D7240 | | | REMOVAL COMPLETE BONY IMPACTIO | Complete description of service |

## MDCH INSTITUTIONAL CLAIM DOCUMENTATION REQUIREMENTS

| CPT/HCPCS Proc Code | Revenue Code | ICD-9-CM Proc Code | Description | Documentation Required |
|---|---|---|---|---|
| J3490 | | | UNCLASSIFIED DRUGS | Complete NDC# (11 digits), Dosage, & Name of Product |
| J3590 | | | Unclassified biologics | Complete NDC# (11 digits), Dosage, & Name of Product |
| J7199 | | | HEMOPHILIA CLOTTING FACTOR, NOC | Complete NDC# (11 digits), Dosage, & Name of Product |
| S0190 | | | MISEPRISTONE ORAL 200 MG | CONSENT & Complete NDC# (11 digits), Dosage, & Name of Product |
| S0191 | | | MISOPROSTOL ORAL 200 MCG | CONSENT & Complete NDC# (11 digits), Dosage, & Name of Product |
| | | 246 | EXPOSURE OF TOOTH | PACER# & PA & OP Report |
| | | 4194 | SPLEEN TRANSPLANTATION | OP Report |
| | | 4469 | GASTRIC REPAIR NEC | PA or Remarks or OP Report |
| | | 6370 | MALE STERILIZATION NOS | Consent |
| | | 6372 | SPERMATIC CORD LIGATION | Consent |
| | | 650 | OOPHOROTOMY | OP Report |
| | | 6501 | LAPAROSC OOPHOROTOMY | OP Report |
| | | 6509 | OTHER OOPHOROTOMY | OP Report |
| | | 653 | UNILATERAL OOPHORECTOMY | OP Report |
| | | 6531 | LAP UNILAT OOPHORECTOMY | OP Report |
| | | 6539 | OTHER UNILAT OOPHORECTOMY | OP Report |
| | | 654 | UNILAT SALPINGO-OOPHOREC | OP Report |
| | | 6541 | LAP UNILAT SALPINGOOOPHORECT | OP Report |
| | | 6549 | OTH UNILAT SALPINGOOPHORECT | OP Report |
| | | 6551 | REMOVE BOTH OVARIES | OP Report |
| | | 6552 | REMOVE SOLITARY OVARY | OP Report |
| | | 6553 | LAP REM BOTH OVAR SAME EPISODE | OP Report |
| | | 6554 | LAPAR REMOV REMAING OVARY | OP Report |
| | | 6561 | REMOVE BOTH TUBES & OVAR | OP Report |
| | | 6562 | REMOVE SOLITARY TUBE/OVA | OP Report |
| | | 6563 | LAP REM BOTH OVAR TUBES SAME E | OP Report |
| | | 6564 | LAP REM REMAIN TUBE & OVARY | OP Report |
| | | 6631 | BILAT TUBAL CRUSHING NEC | Consent |
| | | 6632 | BILAT TUBAL DIVISION NEC | Consent |
| | | 6639 | BILAT TUBAL DESTRUCT NEC | OP Report |
| | | 664 | TOTAL UNILAT SALPINGECT | OP Report |
| | | 6651 | REMOVE BOTH FALLOP TUBES | OP Report |
| | | 6652 | REMOVE SOLITARY FAL TUBE | OP Report |
| | | 6661 | DESTROY FALLOP TUBE LES | OP Report |

## MDCH INSTITUTIONAL CLAIM DOCUMENTATION REQUIREMENTS

| CPT/HCPCS Proc Code | Revenue Code | ICD-9-CM Proc Code | Description | Documentation Required |
|---|---|---|---|---|
| | | 6662 | REMOV TUBE & ECTOP PREG | OP Report |
| | | 6663 | BILAT PART SALPINGEC NOS | OP Report |
| | | 6669 | PARTIAL SALPINGECTOM NEC | OP Report |
| | | 683 | SUBTOT ABD HYSTERECTOMY | Consent |
| | | 684 | TOTAL ABD HYSTERECTOMY | Consent |
| | | 685 | VAGINAL HYSTERECTOMY | Consent |
| | | 6851 | LAP ASSIST VAGINAL HYST | Consent |
| | | 6859 | OTHER VAG HYSTERECTOMY | Consent |
| | | 686 | RADICAL ABD HYSTERECTOMY | Consent |
| | | 687 | RADICAL VAG HYSTERECTOMY | Consent |
| | | 688 | PELVIC EVISCERATION | Consent |
| | | 689 | OTHER + UNSPEC HYSTERECTOMY | Consent |
| | | 6902 | D & C POST DELIVERY | History & Physical |
| | | 6952 | ASPIRAT CURET-POST DELIV | History & Physical |

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## INTRODUCTION

This chapter contains information needed to submit claims to the Michigan Department of Community Health (MDCH) for Medicaid, Children Special Health Care Service (CSHCS), and the State Medical Program (SMP). It also contains information on how claims are processed and how providers are notified of MDCH actions.

The chapter applies to the following list of providers. These providers must use the ASCX12N 837 4010A1 institutional format when submitting electronic claims and the UB 92 claim form for paper claims:

- Hospitals
- Home Health Agencies
- Hospices
- Nursing Facilities
- Private Duty Nursing Agencies

## CLAIMS PROCESSING SYSTEM

All claims submitted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through the CP system are edited for many parameters including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and combination of service edits.

We encourage claims to be sent electronically by file transfer or through the data exchange gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated. Electronic claims filed by Wednesday may be processed as early as the next weekly cycle.

## REMITTANCE ADVICE

Once claims have been submitted and processed through the CP System, a paper remittance advice (RA) will be sent to each provider with adjudicated or pended claims. An electronic health care claim payment/advice (ASC X12N 835 4010A1) will be sent to the designated primary service bureau for providers opting for an electronic RA. See the Remittance Advice section of this chapter for additional information about both the paper and electronic RA.

## ADDITIONAL RESOURCES

**Medicaid Provider Manual:** This manual contains Medicaid policy and special billing information. The manual is available at a nominal cost from the MDCH. Ordering information is available by calling (517) 241-7903, and on the MDCH website.

**Medicaid Bulletins:** These intermittent publications supplement the Medicaid Provider Manual. Bulletins are automatically mailed to enrolled providers affected by the bulletin and subscribers of the Manual. Recent bulletins can be found on the MDCH website at www.michigan.gov/mdch.

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

**Medicaid Databases:** These databases list procedure codes, descriptions, fee screens, and other pertinent coverage, documentation, and billing indicators. They are available on the MDCH website.

> **Note:** Find the MCH website at www.michigan.gov/mdch. Click on Providers, Information for Medicaid Providers, Medicaid Fee Screens.

**HCPCS Codes:** The Health Care Financing Administration Common Procedure Coding System (HCPCS) code book lists national codes and must be purchased annually. This publication is available from many sources, including 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.

**ICD-9-CM:** This diagnosis code manual can be obtained from multiple publishers including the American Medical Association at 1-800-621-8335; Ingenix at 1-800-999-4600; Practice Management Information at 1-800-633-7467; or St. Anthony Publishing at 1-800-632-0123.

**Uniform Billing 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.

**Forms Requests:** Many required forms are available on the MDCH website at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Medicaid Provider Forms and Other Resources. Forms may also be ordered at the address noted below, or faxed. All forms orders must include provider name, Medicaid ID number, mailing address, the name and telephone number of a contact person, the form name and number, and the quantity requested. Quantities requested should be limited to a three month supply.

MDCH/Forms Distribution
Lewis Cass Bldg.
320 S. Walnut St.
Lansing, Michigan 48913

Fax: 517-241-1164

Providers should allow four weeks for delivery.

**Electronic Funds Transfer (EFT):** To initiate an EFT, the facility should go to the Department of Management and Budget website at: www.cpexpress.state.mi.us .

> Additional resource information is available in the Directory Appendix of this manual.

## 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. Electronic claims can be submitted in several ways including file transfer or through the data exchange gateway. The electronic format is the ANSI X12N 837, version 4010A1 institutional. Providers must use this version.

For information on submission of electronic claims, go to the MDCH website at: www.michigan.gov/mdch. The MDCH Electronic Billing Manual and other resources such as the companion guides are located there. Information will be updated on the website as version changes occur at the national level and the department adopts those changes.

## AUTHORIZED ELECTRONIC BILLING AGENT

Any entity (service bureau or individual provider) that wishes to submit claims electronically to the MDCH must be an authorized electronic billing agent. The authorization process is easy:

1. Contact the MDCH Automated Billing Unit for an application packet. (See information below.)
2. Complete and submit the forms in the application packet (an application and a participation agreement),
3. Receive an identification number,
4. Format and submit test files,
5. Once test files are approved, receive full authorization from MDCH to bill electronically.

Once you are an authorized electronic billing agent, any provider (including yourself) who wants you to submit claims on their behalf must complete and submit the Billing Agent Authorization (DCH-1343) form to the MDCH. This form certifies that all services the provider has rendered are in compliance with Medicaid's guidelines. MDCH will notify each provider when it has been processed. After notification, you can begin billing electronically for yourself or other providers that have been approved to use you as their billing agent. More than one billing agent may submit claims for a provider. Only one agent may be the designated receiver of the Health Care Claim Payment/Advice (ANSI X12N 835). (Refer to the Remittance Advice Section of this Chapter for additional information.) Authorizations remain in effect unless otherwise indicated in writing by the provider.

The electronic billing agent authorization process, specifications for test files, specific information about electronic billing and the transaction set for professional claims can be found on the MDCH website. Test claims will not be processed for payment. Any live claims for services rendered must be billed on paper until the authorization process is complete.

Any individual provider can submit claims electronically as long as the authorization process is completed; however, many providers find it easier to use an existing authorized billing agent to submit claims to the program. The billing agent takes claim information gathered from all of its clients and formats it to HIPAA-compliant MDCH standards. The data are then sent to the MDCH for processing. Whether you submit claims directly or through another authorized billing agent, a paper remittance advice (RA), which reflects your individual claims will be generated.

**For more information on becoming a 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

Providers who bill electronically may submit documentation separately using the following process:

Documentation must have the following information, in the order indicated. The information must appear in the upper right hand corner of each page:

- Beneficiary ID number (eight characters)
- Provider ID number
- From date of service
- The page number of the documentation (such as page 1 of 5, page 2 of 5, etc.)

AND

All documentation must be submitted:

- on 8 ½ by 11" paper
- Microfilm ready. This means that the facility must copy and insert face up the back page, immediately following the front page, for each two-sided original page. This will allow us the complete microfilming of the submitted documentation.

If the documentation is correct, it will be filed for use in processing only electronic claims.

Mail documentation to:

MDCH/Medicaid Payments Division
PO Box 30732
Lansing, MI 48909-8232

When the provider electronically bills us they must submit the required documentation at that time. The claim should indicate in the remarks that documentation was sent separately.

**Example:** History and physical sent separately, or prior authorization sent separately or remittance advices verifying time limit exception sent separately.

## 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. An Optical Character Reader (OCR) scans paper claims.

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.

**Note**: Dot matrix printers result in frequent misreads by the OCR and should not be used.

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 in the format MMDDYY. 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 correction fluid 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 ATTACHMENTS WITH PAPER CLAIM FORMS

When a claim attachment is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID number.

Attachments 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 paper claim forms with attachments must be mailed to:

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

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## GENERAL INFORMATION

It is the provider's responsibility to determine eligibility/enrollment status of patients at time of treatment and obtain the appropriate authorizations for payment.

Medicaid, Children's Special Health Care Services (CSHCS), State Medical Program (SMP) beneficiaries may lose their eligibility or change enrollment status on a monthly basis. Enrollment status change includes a beneficiary changing from FFS (Fee-For-Service Medicaid or CSHCS) to a Medicaid Health Plan (MHP) or CSHCS Special Health Plan (SHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary.

Medicaid beneficiaries who have CSHCS coverage are excluded from enrollment in a Medicaid Health Plan.

- When a beneficiary becomes enrolled in CSHCS, he/she will be disenrolled from the MHP.
- Upon review, MDCH may initiate a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined.
- Responsibility of payment transfers from the MHP to FFS on the effective date of the disenrollment.
- Providers are advised to check the Eligibility Verification System (EVS) for changes of enrollment status prior to billing.

## ONGOING SERVICE NEEDS AND EXTENDED TREATMENT PLANS

It is important that the provider verify eligibility/enrollment status before each service is rendered, particularly on the first day of a new month. Even though a patient may be involved in an ongoing treatment or care plan, a change in enrollment status will require new authorization from the new responsible party. Enrollment in a health plan will always trigger an authorization process under the new or "current" health plan. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan. The new health plan must assess the need for continuing services and authorize them as appropriate. Health plans should facilitate the transition between providers to ensure continuity of care for the beneficiary.

***Example:*** A beneficiary is in FFS in June. On June 15, the DCH authorizes a breast reconstruction after mastectomy for breast cancer. The surgery is scheduled for July 20. On July 1, the beneficiary is enrolled in a health plan with the same primary care provider and surgeon. The surgeon must follow the health plan process for authorization of the reconstructive surgery as the plan is now the payer, not FFS. The MDCH authorization would be void.

***Example:*** A beneficiary is in health plan "A" in July and is involved in a course of physical therapy (PT). The therapy program was authorized for six weeks. On August 1, the beneficiary changes enrollment to health plan "B" and still has two more scheduled weeks of PT. Before PT can continue, the provider must obtain a new authorization from health plan "B." Ideally, as a plan-to-plan change occurs at the request of the beneficiary, the provider would coordinate the transition to the new plan, maintain continuity of care and have an authorization in place from plan "B" so the ongoing PT is not interrupted. However, if PT

continues without new plan "B" authorization, plan "A" is not responsible and plan "B" may or may not honor the treatment. The provider cannot bill the beneficiary as the services are covered and it is the provider's responsibility to verify eligibility/enrollment changes and obtain any necessary authorization.

**CSHCS Exception:** SHPs are responsible for reimbursement of established treatment plans and paying current providers for incoming beneficiaries until an Individualized Health Care Plan (IHCP) is developed. The completed IHCP defines authorized services. Additional services require authorization by the SHP. Established providers will be notified if services are to continue through that provider.

**Billing Issues**

MDCH policy directs providers to bill the date of delivery for durable items or equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the Comments/Remarks. This is especially important when a person changes from FFS to a health plan.

## GENERAL INFORMATION

The provider must report the actual payment and/or deductible. MDCH compares the Medicaid fee screen to the Medicare payment amount. If the Medicare payment is less than the Medicaid fee screen, MDCH will pay the lesser of the coinsurance/deductible or the difference between the Medicare payment and the MDCH fee screen. If the Medicare payment exceeds the MDCH fee screen for the service, no payment will be made. If there is not a MDCH established fee screen, we use Medicare's allowed amount and pay up to the full co-insurance and/or deductible.

If the beneficiary is in a Medicare Risk HMO, MDCH pays fixed co-pays on the services up to the lesser of MDCH's allowable amount for the service or the beneficiary's payment liability, as long as the rules of the HMO are followed.

## APPLYING FOR MEDICARE

If a Medicaid beneficiary is eligible for Medicare (65 years old or older) but has not applied for Medicare coverage, Medicaid will not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to Medicaid as long as all program policies (such as time limit for claim submission) have been met.

**Exception:** If the beneficiary is an alien who is 65 years old or older, Medicare coverage is not required. An alien is a person who has been in the United States for less than five consecutive years, thus precluding Medicare coverage. For services to aliens who have Medicaid, indicate in the Remarks section:

1. "Alien"
2. Date of entry
3. Port of entry

## MEDICARE PART A BUY-IN

MDCH has a program, which retroactively (within MDCH time limits) purchases Medicare Part A for beneficiaries age 65 and over who incur such expenses. When a beneficiary has incurred Part A charges and is eligible for Part A buy-in, the Medicaid claim will be rejected. The provider must then submit the claim to Medicare.

Providers should be aware that it usually takes Medicare 120 days to process eligibility and it is the provider's responsibility to keep the claim active with the Medicaid program to avoid exceeding the 12-month billing limitation. After Medicare payment has been received, the provider may bill MDCH for any coinsurance/deductible balance due.

Refer to the Coordination of Benefits chapter for further information when a beneficiary is eligible for both Medicare and Medicaid.

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## GENERAL INFORMATION

The information in this section should be used in conjunction with the Uniform Billing Manual when preparing hospital claims.

# INPATIENT

The following Section references situations that require completing the inpatient claim in a special manner. Medicare Buy-In, readmissions, transfers, private rooms, multi-page billing, fiscal year-end split billing, interim billing, loss of eligibility, and change in enrollment are addressed. The Section also addresses special billing instructions for rehabilitation units of general hospitals.

## ACCOMMODATIONS

The hospital must use the appropriate revenue code that best indicates the type of room the beneficiary occupied. If during a stay the beneficiary occupies more than one room, each having a different rate, the individual accommodation charge for each room must be entered on a separate claim line.

Personal comfort and convenience items (e.g., telephone, television) are not covered by Medicaid and cannot be used to offset the beneficiary-pay amount. Charges for these services must not be included on the claim.

### PRIVATE ROOMS

The program will cover private rooms only when determined to be medically necessary. Condition code **39** (**Private Room Medically Necessary**) must appear on the claim.

If neither a semi-private or multi-bed room is available, a patient may be placed in a private room.

**Billing Instructions:**

- Bill the appropriate revenue code for the private room.
- The charge should reflect the semi-private room rate.
- Condition code **38 (Semi-Private Room Not Available)** must appear on the claim.

Beneficiaries who request a private room when it is not determined medically necessary must be informed in advance that they will be responsible for the entire private room charge. Hospitals must assure that the beneficiary understands that the Medicaid Program will not pay for any part of the private room charge and that the beneficiary assumes responsibility for the entire charge.

## INTENSIVE CARE

Revenue Code 0200 is to be used if the hospital does not have a specific cost center for a specific type of intensive care. Revenue Codes 0201 through 0208 are to be used if the hospital has the specific type of intensive care unit the codes define. Refer to the Uniform Billing Manual for the revenue codes and their definitions.

## AUTHORIZATION OF ADMISSIONS & SERVICES (INCLUDING CHANGE IN ENROLLMENT)

The following guidelines are intended to assist providers and health plans with common concerns regarding authorization of services and payment responsibility, particularly when a change in enrollment status has occurred.

- All admissions (other than emergency admissions) require prior authorization. Medical/surgical (non-psychiatric) admissions must be authorized by the MDCH or its Admissions & Certification Review Contractor (ACRC) for Fee For Service (FFS), or by the health plan in which the beneficiary is enrolled. All psychiatric admissions must be authorized by the local Prepaid Inpatient Hospital Plan (PIHP)/Community Mental Health Service Program (CMHSP).
- Services provided during the admission may also require prior authorization for health plan enrollees. Providers must be aware of the beneficiary's enrollment status and of health plan requirements and processes for authorization. Consultations, surgical procedures, and diagnostic tests will not be reimbursed unless a health plan's authorization process is followed.
- If a beneficiary is admitted by the local PIHP/CMHSP, the admission and all psychiatric services are the responsibility of the PIHP/CMHSP. For a beneficiary enrolled in a Medicaid Health Plan, any non-psychiatric medical/surgical services needed during a psychiatric admission are the responsibility of the health plan and must be authorized by the health plan. For a beneficiary in FFS, the non-psychiatric medical/surgical services should be billed to the program. This would include transportation to another facility for medical/surgical services. If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the PIHP/CMHSP must be contacted for authorization and is then responsible for payment for the psychiatric services.
- If a beneficiary is admitted to an inpatient hospital facility and the enrollment status changes during the admission (e.g. a FFS beneficiary enrolls in a MHP), payment for all services provided until the date of discharge is the responsibility of the payer at the time of admission. Services provided after discharge are the responsibility of the new payer. The discharge planning process should include the new payer for authorization of any medically necessary services or treatments required after discharge from the hospital.
- If a beneficiary is transferred from one inpatient hospital to another inpatient hospital, this **does not** constitute a *discharge*. The payer at admission is the responsible party until the beneficiary is discharged from the inpatient hospital setting to a non-hospital setting.

***Example:*** A FFS beneficiary is admitted on 9-15, enrolled in a health plan on 10-1, and discharged from the hospital on 10-5. The health plan is not responsible for services until 10-5, after discharge. FFS is responsible for the **entire** admission and physician services provided during the admission. The health plan must be contacted at discharge to transition care needs and authorize services needed after

discharge, such as rental of equipment, ongoing medical supply needs, ongoing treatment (e.g., home health care, physical therapy, chemotherapy, IV infusion), etc.

***Example:*** If a beneficiary is in health plan "A" during September and changes to health plan "B" for October, health plan "A" is responsible for the admission. Health plan "B" must be contacted during the discharge planning process and is responsible for authorizing all services needed after discharge.

***Example:*** A beneficiary enrolled in health plan "A" is admitted for authorized surgery in June. The beneficiary is enrolled in health plan "B" on July 1. After surgery, the patient develops complications necessitating a transfer to a tertiary hospital on July 2. The beneficiary is subsequently discharged to home on July 6. Plan "A" is responsible for all hospital and physician services through July 6, and plan "B" is responsible for all services needed after discharge.

***Example:*** A health plan beneficiary is admitted for inpatient psychiatric care by a PIHP/CMHSP. During the admission, the patient requires surgery for medical reasons at another facility. The beneficiary's health plan must authorize the surgery and is responsible for paying for transport between the facilities and for charges related to the surgery.

**Exception**:

MHP beneficiaries who gain CSHCS coverage are disenrolled from the MHP retroactively. Responsibility of payment for the inpatient care during the retroactive time period transfers from the MHP to FFS.

## CHANGES IN OWNERSHIP

When a change in ownership occurs during a beneficiary's stay, two claims must be submitted (one by each provider). The first owner is entitled to payment for the day of transfer.

**Billing Instructions:**

- The first claim must show the appropriate patient status code and a "through" date equal to the last day of ownership. The second claim must show the "From" date as the first day of ownership.
- The second claim must show the same admission date as the first claim.
- If a PACER number was required for the admission, both claims must use the same PACER number.
- "Change in ownership" must be stated in Remarks on the second claim.

## FISCAL YEAR-END / INTERIM BILLING (DRG HOSPITALS ONLY)

Hospitals reimbursed under the DRG system generally cannot submit interim billings. The hospital must wait until the beneficiary is discharged and then bill for all services on claim. However, if a patient has been continuously hospitalized for at least one year and is expected to remain hospitalized for at least another six months, the hospital may submit a claim as if the patient has been discharged. At least every 3 months thereafter, the hospital should submit a replacement claim, which alters the date of discharge and increases the charges. The Remarks Section of the replacement claim must indicate the reason for filing (i.e. interim billing due to extended length of stay).

## HYSTERECTOMY INFORMATION REQUIREMENTS

To encourage paperless billing and reduce administrative burden, the MDCH allows for submission of the Acknowledgement of Receipt of Hysterectomy Information forms (MSA-2218) via fax. Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. This process can eliminate submitting paper attachments for hysterectomy claims, and will pre-confirm the acceptability of the completed acknowledgement form, as well as reduce costly claim rejections.

The provider who obtains the required acknowledgement and completes the MSA-2218 may fax the completed form, along with a cover sheet, to the Payment Processing Division. The form will be reviewed within five working days. Either an explanation of errors, or notice that the form has been accepted and is on file, will be returned to the submitting provider. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted without attachments.

### PROCEDURE FOR ACKNOWLEDGEMENT FORM (MSA-2218) APPROVAL:

- Complete a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed acknowledgement form to: Hysterectomy Acknowledgement Form Approval, fax number 517-241-7856. **Do not fax claims**.
- Wait for a response from the MDCH. When you are notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response.
- If there is no response within five working days: Confirm that your fax is working. Be sure that your cover sheet included the necessary information for Medicaid staff to contact you. Resend the information if necessary.
- You and other providers may then submit claims (either electronic or hard copy) to Medicaid. The Remarks Section or Comment Record of the claim must include the statement "Acknowledgement on File."
- When hysterectomy claims are received with this information in the Remarks, acknowledgement form edit requirements will be forced if the submitted invoice matches the acknowledgement form on file.

**Note:** This process is an option. You may still continue to include a copy of the acknowledgement form to your claim without going through this pre-approval process. If choosing to attach a paper copy of the MSA-2218 with your claim indicate "submitted attachment" in the Remarks Section.

## 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 the beneficiary loses or gains Medicaid eligibility during a hospital stay, the hospital must bill only for the Medicaid-eligible days.

**Billing Instructions:**

- 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.

## MEDICARE

For Medicare Parts A and B/Medicaid claims, Medicaid will only pay up to a Medicare-enrolled beneficiary's obligation to pay (i.e., co-insurance and deductible) or the Medicaid DRG, whichever is less. Medicaid payment will not include capital and direct medical education.

For Medicare Part B/ Medicaid claims where Medicare Part A is exhausted, Medicaid will pay appropriate co-pays and deductibles up to the beneficiary's financial obligation to pay or the Medicaid DRG (or per diem rate) less the total amount paid by all other payers, whichever is less. Medicaid reimbursement will include capital and direct medical education (made at final settlement).

### MEDICARE PART A EXHAUSTED PRIOR TO STAY

**Billing Instructions:**

- Enter occurrence code A3 and the date when Medicare Part A exhausted
- Non-covered days must be reflected on the claim to be paid correctly
- Medicare Part B payment must be reflected on the claim.

### MEDICARE PART A EXHAUSTED DURING STAY

**Billing Instructions:**

- Enter occurrence code A3 and the date when Medicare Part A exhausted
- The Medicare payment must be reflected on the claim
- Report value code A2 (coinsurance)

### MEDICARE PART A BECOMES EFFECTIVE DURING STAY

**Billing Instructions:**

- Enter occurrence code A2 and the date when Medicare Part A becomes effective
- The Medicare payment must be reflected on the claim
- Report appropriate value codes A1 (deductible) and/or A2 (coinsurance) if applicable

## MULTI-PAGE CLAIM (PAPER CLAIM)

Inpatient hospitals can report charges on multiple pages when services exceed more than 22 lines.

**Billing Instructions:**

- Enter revenue code “0099” and “ADDL PG” on claim line 23 for all pages except the last page. On the last page enter revenue code “0001” and “TOTAL” on claim line 23.
- When billing for Nursery/ICU accommodation charges, **at least one** Nursery/ICU revenue code **must** appear on the last page of the claim for proper DRG assignment.
- When billing for leave of absence charges, revenue code "0180" **must** appear on the last page for correct reimbursement.

### MULTI- PAGE CLAIM REPLACEMENT

When a multiple-page approved claim requires changes to revenue codes and/or charges, a replacement claim should be submitted for all the pages.

**Billing Instructions:**

For all pages (except the last page) of a multi-page replacement claim:

- Enter revenue code “0099” and “ADDL PG” on claim line 23
- On the last page of the replacement claim, enter on claim line 23 revenue code “0001”and ‘TOTAL”,
- Enter type of bill “117” in F.L. 4.
- Enter the claim reference number (CRN) of the claim being replaced in F.L. 37.

When information that affects the entire claim needs to be corrected (i.e., diagnosis coding, other insurance payments, etc.), replace only the claim with an approved dollar amount greater than zero. The DRG assignment and/or amount approved may be changed.

## NEWBORN ELIGIBILITY

All newborn services must be billed under the newborn’s ID number. The hospital **may not** bill under the mother’s ID number. If an ID number has not been assigned prior to or at the time of delivery, the hospital may submit a Facility Admission Notice form (MSA-2565-C) to the local FIA office. The local office will then return the MSA-2565-C to the hospital. The provider must not bill until the Eligibility Verification System shows the newborn’s ID number, date of birth and the sex. Refer to the Forms Appendix for more information regarding the MSA-2565-C.

**Note:** If the mother is enrolled with a Medicaid Health Plan at the time of birth, all newborn charges must be billed to the Medicaid Health Plan.

If the newborn does not yet have a Medicaid ID number and a readmission occurs, the PACER number may be obtained under the mother’s name and ID number.

**Billing Instructions:** Indicate in the "Remarks" the mother's ID number and "PACER number was obtained under mother's ID number".

## PATIENT PAY AMOUNT

Value code D3 followed by the dollar amount is used to reflect the patient pay amount.

When the patient pay amount is sufficient to cover the cost of the entire admission, the facility should not submit a bill to Medicaid nor bill the beneficiary for any balance between the facility charges and the patient pay amount.

When the patient is admitted as an inpatient from a nursing facility, the admission source code must be a "5", otherwise patient pay amount will be deducted in error. This is used whether the patient was admitted through the emergency room from the nursing facility or directly from the nursing facility. If the patient is admitted through the emergency room, the emergency room charges must be included on the inpatient claim.

If the beneficiary is discharged and/or transferred to another facility within the same calendar month, the first facility collects the patient pay amount. If patient pay amount was deducted from the second admission in error, a claim replacement must be submitted.

When the admission spans two or more months, the facility must collect the patient pay amount for each month the beneficiary is in the facility.

## PRE-ADMISSION CERTIFICATION EVALUATION REVIEW (PACER)

Elective admissions, readmissions within 15 days for other than the same/related condition, and all transfers for surgical, medical and rehabilitation inpatient services require approval by the MDCH's Admission and Certificate Review Contractor (ACRC).

**Note:** If the beneficiary is enrolled in an MHP, the MHP must be contacted for prior approval. For each circumstance in which a PACER number is required for FFS beneficiaries, a prior authorization is required for MHP enrollees.

**Billing Instructions:**

The PACER number obtained from the ACRC must be entered in the Treatment Authorization field on the claim.

The following **do not** require prior authorization through the PACER system:

- Urgent or emergent admissions including OB patients admitted for any delivery. Newborn stays also do not require a PACER number. If the newborn does not yet have Medicaid ID number and needs to readmitted, the PACER number may be obtained under the mother's name and ID number.

  **Note:** When billing with newborn's ID number indicate in the Remarks section:
  1) the mother's ID number and
  2) "PACER number obtained under mother's ID number."

- Admissions of beneficiaries that are eligible for CSHCS only.
- Transfers to state psychiatric hospitals.
- Medicare Part A beneficiaries
- Admission in which a beneficiary is determined Medicaid-eligible after the admission has occurred for which preadmission certification was required.

  **Note:** "Retroactive eligibility" must be stated in Remarks.
- Admission to a hospital not enrolled with Medicaid.

## READMISSIONS (DRG HOSPITALS ONLY)

Under the fee for service DRG reimbursement system, payment is intended to include all services required to treat the beneficiary. Since payment is made on a per case basis, incentives exist to inappropriately increase the number of cases (admissions), or to discharge patients early, in order to allow for new admissions and to maximize revenue. An early discharge could further increase the number of potential hospital readmissions. For these reasons, Michigan's DRG system is designed to carefully monitor and control readmissions.

The MDCH defines a readmission as any admission/hospitalization within 15 days of a previous discharge, whether the readmission is to the same or different hospital.

**Example:** If a beneficiary is discharged on November 13, 2002 and is readmitted **before** November 28, 2002, this is considered a readmission within 15 days. (Count the day of the original discharge and the day of readmission.) If the beneficiary is discharged on November 13, 2002, and is readmitted **on** November 28, 2002 this is considered a new admission (the beneficiary is discharged and readmitted **after** 15 days have elapsed).

The MDCH reviews hospital claims on a pre-payment basis and through its ACRC contractor on a post-payment basis to determine the appropriateness of readmissions. If the MDCH determines that a readmission within 15 days was inappropriate, monies will be recovered from the admitting physician **as well as** the hospital.

## READMISSION WITHIN 15 DAYS TO THE SAME HOSPITAL (UNRELATED READMISSION)

If a beneficiary is readmitted to the same hospital within 15 days for a **condition(s) unrelated** to the previous admission (e.g., admission for gall bladder removal, readmission for multiple injuries due to car accident), the Program will consider the case a new admission for payment purposes. A PACER number for the readmission **is** required.

**Billing Instructions:** The hospital must complete two claims: one for the admission and one for the readmission. When completing the <u>second claim</u>, the hospital <u>must</u> indicate the PACER number in the treatment authorization field and Occurrence Span Code 71 with "from" and "through" dates from the previous admission.

## READMISSION WITHIN 15 DAYS TO THE SAME HOSPITAL (RELATED ADMISSION)

If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, the Program will consider the admission and the readmission as one episode for payment purposes. No PACER number will be issued for continuation of care.

**Billing Instructions:**

- Revenue code 0180 is used for the days the beneficiary was not in the hospital.
- Enter the number of leave days in the "service unit" item
- Leave the rate and total charges blank
- Include the leave days units in the total units
- Report Occurrence Span Code 74 with “from” and “through” dates of the leave of absence.

**Note:** If the original admission has been submitted and paid, a replacement claim that contains the combined services for the original admission and readmission **must** be submitted.

### READMISSION WITHIN 15 DAYS TO A DIFFERENT HOSPITAL

If a beneficiary is readmitted to a different hospital within 15 days for a related or unrelated condition, a PACER number is required. Enter the PACER number in the "treatment authorization" field and Occurrence Span Code 71 with “from” and “through” date from the previous admission.

### TRANSFERS:

If a beneficiary needs to be transferred from one hospital to another, or one unit to another in which the hospital is assigned a different provider ID number, **a PACER number is needed**.

Prior authorization for a transfer will only be granted if the transfer is medically necessary and the care/treatment is not available at the transferring hospital. Transfer for convenience will not be considered. Authorization should be obtained by the next working day for urgent or emergent transfers.

Billing Instructions:

- The receiving hospital enters the PACER number of the approved transfer in the treatment authorization field.
- It is not necessary to submit documentation when billing transfers.

The receiving physician may obtain the PACER number (prior to discharge) for an urgent or emergent transfer if the transferring physician failed to do so. In the event that a transfer is determined to be inappropriate, monies will be recovered from the transferring hospital on a post-payment review basis.

## REHABILITATION UNITS

Medicare-recognized, distinct-part rehabilitation units must be enrolled with a separate provi der type 30 ID number. This distinct rehabilitation unit number must be used on claims when billing for rehabilitation services. A PACER number must also be obtained for an elective admission or transfer to a distinct-part rehabilitation unit.

**Billing Instructions:** The PACER number must be entered on the hospital claim in the "treatment authorization" field.

Inpatient stays in a distinct-part rehabilitation unit beyond 30 days require additional inpatient authorization by contacting ACRC. This phone call should take place between the 27th and 30th day of stay. If the extended stay is certified, a PACER number will be issued.

**Billing Instructions:** The PACER number must be entered on the claim in the "treatment authorization" field.

The hospital should call ACRC between the 57th and 60th day if the stay is expected to exceed 60 days. If the extended stay is certified, a PACER number will be issued.

**Billing Instructions:** The PACER number must be entered on the claim in the "treatment authorization" field.

## STERILIZATION

Refer to the Hospital Coverage chapter for coverage policy information. Refer to the Forms Appendix for a copy of the Informed Consent to Sterilization form (MSA-1959), including completion instructions. If any field on the form is improperly completed your claim will be rejected.

### PROCEDURE FOR INFORMED CONSENT TO STERILIZATION (MSA-1959) APPROVAL

- Complete a cover sheet (typed or printed) which must include beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed Informed Consent to Sterilization to fax 517-241-7856. **Do not fax claims**.
- Wait for a response. When you are notified that the MSA-1959 has been accepted and is on file, inform the other providers via a copy of the response.
- If there is no response within five working days: Confirm that your fax is working. Be sure that your cover sheet included the necessary information for Medicaid staff to contact you. Resend the information if necessary.
- You and other providers may then submit claims (either electronic or paper) to Medicaid. The "Remarks Section" or "Comment Record" must include the statement "Consent on File."
- The information on the sterilization claim must match the information on the consent form. If it does not, the claim will be rejected.

**Note:** This process is an option. You may include a copy of the Informed Consent to Sterilization form with your claim without going through this pre-approval process. If choosing to include a paper copy of the MSA-1959, indicate "submitted attachment" in the Remarks Section.

## TRANSPLANTS

**Heart, bone marrow**, **liver**, **lung, simultaneous pancreas/kidney and pancreas transplants** are reimbursed at the hospital’s Medicaid cost-to-charge ratio.

**Billing Instructions:**

- The letter of authorization for the transplant from the Office of Medical Affairs or MHP must be attached to all transplant claims; otherwise, payment will be denied.
- Indicate ”prior authorization letter submitted” in the "Remarks Section" of the submitted claim.
- For other transplant services not described by a specific DRG, identify in the "Remarks Section" the type of transplant that has been performed (i.e. ”small bowel transplant").

If the donor and beneficiary are both Medicaid eligible, you must bill the services under their respective ID Numbers. If only the beneficiary is Medicaid eligible, bill services for both donor and beneficiary under the Medicaid beneficiary’s ID Number.

**Note:** All other insurance resources must be exhausted before Medicaid is billed. If Medicare eligibility is denied, the denial notice must be submitted with the claim.

## OUTPATIENT

The following sub-section references situations that require completing the outpatient claim in a special manner.

## ANESTHESIA

- A 037X category Revenue Code should be billed. These codes are used to bill for anesthesia supplies which include oxygen gases, mask, breathing circuit, cannulas, anesthesia drugs, etc.
- The quantity must be “1”.
- A HCPCS code that supports the facility charges for the services reported must be entered at least once on the claim.
- When billing for services that do not normally require anesthesia services, enter in Remarks “general anesthesia required”.

CRNA professional charges should not be included in the outpatient hospital bill. See the Billing and Reimbursement Chapter for Health Care Professionals for additional information.

## APHERESIS / THERAPEUTIC

- Room charges for apheresis must be billed under Revenue Code 0260 - IV Therapy.
- A supporting HCPCS code must be listed in F.L. 44.
- Supplies may be billed under Revenue Code 0264.
- Pharmaceuticals may be billed under Revenue Code 0250.

It is not necessary to repeat the supporting HCPCS code for the multiple hospital charge revenue codes.

## BLOOD HANDLING

Blood handling may be billed if the drawing, packaging, and mailing of a blood sample are the only services provided. Revenue code 0300 with CPT/ HCPCS code 36415, "routine venipuncture for collection of specimen(s)," and the usual and customary charge for the service must be used. The "Remarks" section of the claim must indicate the reason the blood was obtained as a separate service and the reason the laboratory that performed the testing could not also perform the venipuncture.

## BLOOD NOT REPLACED

- "Blood not replaced" must be billed using Revenue Code series 038X or 039X.
- Indicate in the "Units of Service" the number of units of blood that were used.
- If appropriate, you may bill Revenue Code 038X and the 039X series together with the appropriate supporting HCPCS code on **the claim**.
- Use revenue code 0260 for transfusion service with CPT/HCPCS code 36430.

Refer to the "Intravenous Infusion" portion of this section for other related services billing instruction.

## CARDIAC CATHETERIZATIONS

The room charge for use of the cardiac cath lab must be billed using Revenue Code 0481. Report the quantity of "1" for each hour of cath lab time, up to a quantity of "2" hours. The supporting cardiac catheterization HCPCS code must be reported.

When multiple injection procedures are performed during the cardiac catheterization, report revenue code 0489 with CPT/HCPCS code 93555 and/or 93556 as appropriate. These CPT/HCPCS codes may be reported only once on the claim.

Additional charges and a separate reimbursement for pharmacy, supplies, anesthesia, etc. used during the procedure may be billed using the appropriate revenue codes listed below.

0621 Supplies/Incident to Radiology

0255 Pharmacy/Incident to Radiology
0371 Anesthesia/Incident to Radiology

**NOTE:** All surgical supply revenue codes should be reported on the same claim as revenue code 0481 to be paid a percent of charge for supplies utilized during the reported surgical procedure.

Report observation room charges with revenue code 0762 (Observation Room) quantity “1”. If acute care recovery is necessary, report this service under Revenue Code 0710 (Recovery Room), reporting the quantity as "1" for each 30 minutes of time in the recovery room, up to a total of four hours, in Form Locator 46. You must report these items on the same bill as the cardiac catheterization procedure.

## CHEMOTHERAPY TREATMENT

The cost of the antineoplastic drugs must be billed using revenue code 0636 and the appropriate CPT/HCPCS (J code) code **on the claim line**. The quantity should reflect the number of vials or ampules used to achieve the total dosage given.

**Example:** 70 mg of Adriamycin would be billed using code J9000 with a quantity of 7.

850 mg of 5FU would be billed using code J9190 with a quantity of 2.

Chemotherapy treatment requires a supporting HCPCS code to be reported **on the claim** to support the facility charges. The appropriate revenue code from the 033X series must be billed for hospital room charges. Related supplies should be billed using revenue code 0270. Chemotherapy cannot be series billed.

A clinic room charge **cannot** be billed in addition to chemotherapy services.

## CHILDBIRTH EDUCATION

Childbirth education services must be billed upon completion of the course.

- Use Revenue Code 0229, "Other Special Charges”.
- Enter the last date the beneficiary was seen for childbirth/parenting education in “Statement covers period”. The “from” and “through” dates must be the same.
- The quantity must be reported as “1".

This service does not require a supporting HCPCS code.

## CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

Refer to ”Clinic Services” for reporting CSHCS clinic charges.

## CLINIC SERVICES

Clinic Visit Revenue Codes (0510, 0511, 0514, 0515, 0516, or 0517) must be billed with a quantity of “1”.

A supporting HCPCS code is not required.

## CONTRAST MATERIAL

**Low Osmolar Contrast Material:** Separate additional payment may be made for low osmolar contrast material (LOCM) if used for beneficiaries with at least one of the following characteristics:

- a history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- a history of asthma or allergy;
- significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, or pulmonary hypertension;
- generalized severe debilitation; or
- sickle cell disease.

If the above criteria are met, the LOCM may be billed using Revenue Code 0636 with the appropriate CPT/HCPCS code.

The "Remarks" Section must include:

- Name of the contrast material used (drug),
- The complete eleven-digit NDC# used to identify the specific contrast material used, and
- The actual dosage of the drug (contrast material) given to the patient.

**High Osmolar Contrast Material:** The cost of high osmolar contrast material is reimbursed as part of the technical component of diagnostic radiology procedures and is not to be billed under Revenue Codes 0250, 0255 or 0636.

**Paramagnetic Contrast Material:** Paramagnetic contrast material used in MRI studies is included in the reimbursement for the technical component and will not be paid separately.

## COSMETIC SURGERY

**Billing Instructions:**

- A copy of the letter of authorization for the cosmetic surgery that was sent to the attending physician from the Office of Medical Affairs or MHP must be submitted with the claim.
- Indicate, ”prior authorization letter submitted” in the "Remarks" Section.

## DENTAL SERVICES

Prior authorization is not required for the outpatient hospital setting for FFS beneficiaries. Prior authorization may be required for MHP enrollees.

- The hospital must bill the appropriate supporting HCPCS code, along with the appropriate revenue code(s).
- If the hospital bills an unlisted HCPCS code, a complete description of the service provided must be entered in the "Remarks" Section.

## DIABETES SELF-MANAGEMENT EDUCATION PROGRAM

**Billing Instruction:** Diabetes self-management training services in the outpatient hospital must be reported under revenue code 0942 with CPT/HCPCS code G0108 or G0109 **on the claim line**. Each individual session must be billed on a separate claim line.

## DONOR SEARCHES

Charges for donor searches that do not result in an organ acquisition and transplant should be billed as an outpatient service using Revenue Code 0814. No supporting HCPCS code is required to bill this service.

- A copy of the prior authorization for the transplant that was sent to the attending physician from the Office of Medical Affairs or MHP must be submitted with the claim.
- Indicate ”prior authorization letter submitted” in the "Remarks" Section.

## DRUGS ADMINISTERED ON PREMISES

For products administered in conjunction with laboratory, radiology, or other medical procedures, bill the appropriate revenue code and HCPCS code and include the drug costs in your charges.

For routes of administration other than injectables (e.g., oral, topical, rectal, etc.), bill using Revenue Codes 0250, 0251, 0252, 0257, or 0259. The supporting HCPCS code must be billed **on the claim**.

For low osmolar contrast material (LOCM,) refer to "Contrast Material" in this section.

## EMERGENCY DEPARTMENT SERVICES

Emergency Department services are to be billed as follows:

### EMTALA SCREEN

- Use Revenue Code 0451 with CPT/HCPCS code 99281 when billing the EMTALA screen without follow-up treatment/stabilization services.

- Bill diagnostic procedures per Medicaid fee-for-service policy.

The EMTALA screen can be reported only with Revenue Code 0452 and will not be reimbursed in combination with any other Emergency Department (045x) or Clinic (051x) Revenue Code for fee-for-service Medicaid beneficiaries.

## EMERGENCY DEPARTMENT EMERGENCY TREATMENT SERVICES

- Use Revenue Code 0450 or a combination of 0451 and 0452.
- Use appropriate Emergency Department Evaluation & Management procedure code (99281-99285) to indicate level of service provided.
- All other services, (e.g., pharmacy, x-ray, etc.) must be billed consistent with Medicaid's fee-for-service policy.
- Revenue Code 0450, or combination of 0451 and 0452, will not be separately reimbursed in conjunction with the Revenue Code and Reimbursement Group E (RC 0360, 0369, 0481) on the same visit.
- The principle diagnosis code field must reflect the emergency diagnosis resulting from the EMTALA screen. The admitting diagnosis code field should reflect the beneficiary's reason for the emergency room visit.

  **Exception:** The reason why the encounter was considered an emergency must be entered in the "Remarks" Section if the principal diagnosis, or the admitting diagnosis, does not reflect the BBA's definition of an emergency. The information in the "Remarks" Section should include vital signs, medical problems or conditions noted during the ER visit, if an IV was started, and medications administered during the visit. This information must be adequate to confirm emergent condition.

- All outpatient hospital charges for emergency department services resulting in an inpatient admission must be billed using the Inpatient Hospital provider type and ID number. Payment will be made through the inpatient reimbursement system (as part of the DRG).

## EMERGENCY DEPARTMENT NON-EMERGENCY TREATMENT SERVICES

- Use Revenue Code 0456.
- Use appropriate Emergency Department Evaluation & Management procedure code (99281-99285) to indicate level of service provided.
- All other services (e.g. pharmacy, x-ray, etc.) must be billed consistent with Medicaid's fee-for-service policy.

Medicaid will cover all appropriate hospital charges for emergency department services, as previously defined, provided that the diagnosis supports the procedures billed and/or documentation supports the facility charges.

**Note:** For MHP enrollees, authorization **must** be obtained prior to providing non-emergency services in an Emergency Department.

**MULTIPLE EMERGENCY DEPARTMENT VISITS IN ONE DAY**

Occasionally, the beneficiary may be treated in the emergency department more than once on the same date.

Use Condition Code G0 and, in the "Remarks" Section, include the reason the beneficiary was treated more than once on the same date.

## GASTRO-INTESTINAL SERVICES

The room charge for use of gastro-intestinal services (e.g. Endoscopy, Laparoscopy) must be billed with revenue code 0750 and appropriate CPT/HCPCS code **on the claim line**. Revenue codes 0250, 0258 and 0270 may be billed in addition to revenue code 0750 when provided.

## HEMODIALYSIS AND PERITONEAL DIALYSIS

Dialysis services should be series billed to avoid payment delay.

Bill the appropriate 082X through 085X series Revenue Code.

A supporting HCPCS code is not required.

Enter the first treatment date of the month as the "from" date and the last treatment date as the "through" date for a single calendar month.

The quantity must reflect the total number of treatments in the series for that month.

The charges should reflect the combined charges for the services for that month.

## HYPERBARIC OXYGEN THERAPY

- Hyperbaric Oxygen Therapy must be reported with Revenue Code 0413.
- A supporting HCPCS code must be billed **on the claim**.

This service **cannot** be series billed.

## HYSTERECTOMY (MSA-2218)

See the Inpatient Billing Section of this Chapter for information.

## INDIVIDUAL CONSIDERATION

For requesting individual consideration:

- Report modifier 22 following the CPT/HCPCS code.
- Indicate the reason of request in the "Remarks" Section. For injection procedures refer to “Injections”.

## INJECTIONS

When intramuscular, subcutaneous or intravenous injections are given in the outpatient hospital setting, the hospital must bill using revenue code 0636 "Drugs Requiring Detailed Coding" and the appropriate CPT/HCPCS code on the claim line.

For medications that do not have a specific code, document the dosage, brand name, manufacturer, National Drug Code (NDC) if available, and drug cost in the "Remarks" section of the claim. Enter a quantity of "1" .

When billing a code with a dose-specific description, enter the appropriate quantity. If the dose specified in the code description is exceeded, use modifier 22 and document the actual dosage given in the "Remarks" Section.

## INTRAVENOUS INFUSION

Room and equipment charges for intravenous fluid administration must be billed using Revenue Code 0260, "IV Therapy".

IV solutions (such as dextrose) and saline solutions, used as dilutents/vehicles for drug therapy, must be billed under revenue code 0262, "IV Therapy/Pharmacy Services".

IV solutions used to hydrate, and not in conjunction with drug therapy, must be billed under revenue code 0258, "IV Solutions".

Tubing, syringes, needles, and other miscellaneous items (such as sterile gloves and gauze) used during IV fluid administration must be billed under revenue code 0264, "IV Therapy/Supplies".

A supporting CPT/HCPCS code must be entered once on the claim.

Charges for active drugs administered via intravenous infusion must be billed using revenue code 0636, "Drugs Requiring Detailed Coding", and the appropriate CPT/HCPCS code (J codes) **on the claim line**.

## LABOR AND DELIVERY ROOM

Labor and delivery room charges must only be billed when labor progresses to delivery.

- Bill under revenue codes 0720-0724.

- A supporting HCPCS code is required.
- The units reported for revenue codes 0720 - 0724 must be "1" for each 30 minutes rounded up to the nearest half hour with a maximum of 2 units (1 hour) billable.

Charges for rooms used for a beneficiary in active labor who does not progress to delivery must be billed under Revenue Code 0729, "False Labor". A supporting HCPCS code is not needed. Revenue code 0729 **must not** be billed for fetal monitoring, or treatment of other medical conditions for a beneficiary who is not in active labor. No other room charge may be billed with revenue code 0729 for the same date of service.

For fetal monitoring non-stress test, report revenue code 0920 with CPT/HCPCS code 59025. No other room charges maybe billed in addition to this test.

For other prenatal care, the hospital may bill under revenue code 051x.

## LABORATORY

The date of service indicated on the claim must be the date the specimen is collected.

If the daily reimbursement limit of $75 is exceeded, the outpatient hospital must request an exception to the daily reimbursement limit by submitting documentation of medical necessity for each laboratory procedure. For prompt payment of laboratory procedures that exceed the daily reimbursement limit, all claims for a single date of service should be submitted together, with one copy of the accompanying documentation for each claim, and indicate “submitted attachment” in the "Remarks" Section.

## LATE CHARGES

Late charges do not apply for outpatient hospital (Type of Bill 135). A claim replacement must be submitted to report correct charges.

Refer to the "Replacement & Void/Cancel Claims" Section of this Chapter for additional information.

## MINOR SURGERY/ PROCEDURE

These codes are listed in the revenue code and CPT/ HCPCS code, Minor Surgery/ Procedure list in this section. They identify services that are normally performed in the office setting. The reimbursement for these office-based procedures will be no more in the hospital than the fee paid in the office setting.

Outpatient hospitals must bill Revenue Code 0361 (OR/Minor) and the appropriate CPT/HCPCS code on **the claim line**.

## MULTIPLE SURGICAL PROCEDURES

When multiple surgical procedures are performed at the same session, it is not necessary to bill a separate charge for each procedure, although hospitals continue to have the option of doing so. It is acceptable to bill a single charge under the revenue code that describes where the procedure was performed for the surgical procedure HCPCS code (i.e. RC 0360, "Operating Room"), and bill the other procedures using an acceptable HCPCS code and the same revenue code but with $0.00 in charges.

## MULTIPLE VISITS IN SAME DAY

Multiple medical visits on the same day with the same revenue center, but the visits were distinct, and constituted independent visits, may be submitted on separate claim lines. An example is when a beneficiary going to the emergency room twice on the same day, in the morning for broken foot and later for chest pain.

**Billing Instructions:**

- Report Condition Code G0.
- State the reason for reporting multiple visits in Remarks.

## OBSERVATION ROOM

Observation room charges can only be billed separately for cardiac catheterizations or Myelograms. Report Revenue Code 0762 "Observation Room" with quantity “1.” Observation room charges must be reported on the same claim as the Cardiac Catherterization or Myelogram.

Refer to "Interventional Radiology" or "Cardiac Catheterizations" for additional information.

## OPERATING ROOM

Operating room charges are covered for surgical procedures that require a sterile environment and equipment generally found in an operating room. Charges for preoperative holding rooms or surgical suites are not a covered benefit. If these services are reported separately on the claim, the line will be rejected without payment. The units billed for the operating room **cannot** reflect pre or post surgery room charges.

The unit billed should be "1" for each 30 minutes rounded up to the nearest half hour. For example, if the operation started at 7:50 a.m. and ended at 9:00 a.m. the total time would be 1 hour and 10 minutes. The units billed would be "3". Units up to 6 will be approved for payment. When more than “6” units are reported, use modifier 22 and document the reason for the prolonged time in the Remarks section .

**Note:** Surgical Revenue Codes (0360, 0369) must be billed with a supporting HCPCS code on **the claim**, to support facility charges. All surgical supply revenue codes listed in the Revenue Code and Reimbursement Groups, Category D in this Section should be reported on the same OR claim to be paid a percent of charge for supplies utilized during the reported surgical procedure.

## PERCUTANEOUS TRANS-LUMINAL CORONARY ANGIOPLASTY (PTCA)

Bill room charges for PTCA procedures utilizing the Revenue Codes 0360 "OR services" or 0369 "OR/other". Charges for preoperative holding rooms are not a covered benefit. If pre-procedure holding rooms are billed separately on the claim, the line will be rejected without payment. The quantity for OR room time billed should be "1" for each 30 minutes spent in the OR up to a maximum of two hours.

Disposable, non-reusable items (such as sutures, dressings, etc.) can be reported as supplies. To bill the additional use of supplies, pharmacy, and/or anesthesia report the supporting HCPCS code once **on the claim**. Use the appropriate revenue codes as indicated to identify the items used.

025X Pharmacy 027X Surgical Supplies

0264 IV/Ther/Supplies 037X Anesthesia

**Note:** All surgical supply revenue codes listed in the Revenue Code and Reimbursement Groups, Category D of this Section, should be reported on the same claim to be paid a percent of charge for supplies utilized during the reported surgical procedure.

If "acute" care recovery is necessary, report this service under revenue code 0710 "Recovery Room" reporting the quantity as "1" for each 30 minutes of time in the recovery room, up to a total of four hours. **You must report these items on the same claim as the PTCA procedure.**

## RADIATION TREATMENTS

These services may be series billed.

## RADIOLOGY

Diagnostic and therapeutic x-rays, nuclear medical services, CT scans, MRAs and MRIs must be billed using one of the appropriate revenue codes listed below, along with the supporting HCPCS code reported **on the claim line.**

032X Radiology-Diagnostic
034X Nuclear Medicine
040X Other Imaging Services
0333 Radiology-Therapeutic and/or Chemo Adm.
035X CT Scan
061X MRI/MRA

### INTERVENTIONAL RADIOLOGY

Facility charges may be billed for interventional radiology procedures included on the "Revenue Code and CPT/HCPCS Code" list. Bill revenue code 0369 "OR/other" with the appropriate supporting HCPCS code.

Charges for pre-procedure holding rooms are not a covered benefit. If you bill pre-procedure holding rooms separately on your claim, the entire claim will be rejected without payment.

For Revenue Codes 0360 and 0369, the quantity billed should be "1" for each 30 minutes spent in the OR up to a maximum of three hours.

Disposable, non-reusable items such as sutures, dressings, etc., can be reported as supplies. Use the appropriate revenue codes as indicated below to identify the items used.

0621 Supplies/Incident to Radiology
0255 Pharmacy/Incident to Radiology
0371 Anesthesia/Incident to Radiology

**Note:** All surgical supply revenue codes should be reported on the same claim as revenue code 0369 to be paid a percent of charge for supplies utilized during the reported surgical procedure.

For observation room charges related to the interventional radiology procedure, report revenue code 0762 "Observation Room" with quantity “1.” Observation room charges can only be billed separately for cardiac catheterizations and myelograms. If "acute" care recovery is necessary, report this service under Revenue Code 0710 "Recovery Room" reporting the quantity as "1" for each 30 minutes of time in the recovery room, up to a total of four hours. These items must be reported on the same claim as the myelography.

### MULTIPLE RADIOLOGICAL PROCEDURES

When billing more than one x-ray of the same area on the same day, the hospital must combine the x-ray services on one claim line (revenue code 032X-0330). Use modifier 22, bill a quantity equal to the total number of x-rays provided and document the medical necessity in the Remarks Section of the claim.

Specific information and medical need must be documented (i.e., the medical condition that exists for each x-ray), or no additional payment will be approved. "Quantity of 2" or "medically necessary" entered in the Remarks Section of the claim is not adequate information.

There are several radiology procedures that are considered bilateral procedures by definition of procedure code, e.g., mastoids, orbits, paranasal sinuses, peripheral flow study, bone length studies. Therefore, individual consideration should not be requested when bilateral views are taken.

## RECOVERY ROOM

If "acute" care recovery is provided after a surgical procedure, report this service under Revenue Code 0710 "Recovery Room". Report the quantity as "1" for each 30 minutes of time in the recovery room. A maximum of four hours will be approved for payment. A supporting HCPCS code must be reported once **on the claim**.

**Note:** Revenue code 0360, 0369 or 0481 must be on the claim for the recovery room (revenue code 0710) to be covered.

## SELF-CARE DIALYSIS TRAINING

**Billing Instructions:**

- Bill self-care dialysis training using Revenue Code 0855.
- If a beneficiary completes a course:

- report the "dialysis patient training, complete course," HCPCS code 90989.
- The quantity should be "1."

- If a beneficiary does not complete a course:
  - report each session separately using the “dialysis patient training, per session HCPCS code 90993.
  - The service date on the claim line must indicate the actual date that the session occurred.
  - A quantity of "1" must be entered, not to exceed a maximum of 9 sessions per course.

## SERIES BILLING

Certain services (listed below) of the same type (i.e., same procedure code) rendered to one beneficiary in a single calendar month may be billed on one claim line, (i.e., series billed).

hemodialysis
peritoneal dialysis
occupational therapy
physical therapy
speech pathology
radiation treatment delivery

**Billing Instructions:**

- Enter the first treatment date of the month as the “from” date and the last treatment date as the “through” date for a single calendar month.
- The quantity should reflect the total number of treatments in the series for that month,
- the combined charges for the services for that month should be used.
- Occupational, physical and speech-language therapy revenue codes should be billed using the appropriate HCPCS code that describes the therapy service provided.
- Enter a quantity of “1” for every 15 minutes of therapy provided if the HCPCS code indicates 15 minute intervals of service.
- Enter the actual dates of service for that month in the Remarks section for each revenue code billed.

## STERILIZATION

See the Inpatient Hospital Section for instructions.

## THERAPIES (OCCUPATIONAL, PHYSICAL, AND SPEECH-LANGUAGE)

### OCCUPATIONAL THERAPY

Occupational therapy does not require prior authorization for a maximum of 36 visits within the first 90 consecutive calendar days of therapy. For MHP enrollees, the provider should check with the MHP for prior authorization requirements.

Occupational therapy must be billed with the 43X series revenue codes along with the appropriate CPT/HCPCS code **on the claim line**. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity.

Therapy must be provided by the evaluating discipline. Medicaid covers the occupational therapy evaluation/reevaluation without prior authorization twice in a 365-day period. Report revenue code 0434 with CPT/HCPCS code 97003 "evaluation" or 97004 "reevaluation" with quantity of "1." Evaluation or reevaluation cannot be paid when it is billed with other occupational therapy services on the same day. Occupational therapy may be series billed.

The fee for occupational therapy includes all services. The hospital cannot bill a clinic room charge in addition to the therapy, unless the visit is unrelated to occupational therapy.

Occupational therapy may be provided to nursing facility beneficiaries by the outpatient department of a general hospital.

Prior authorization is required for continuing therapy beyond the initial 90 days of therapy.

## PHYSICAL THERAPY

Physical therapy does not require prior authorization for a maximum of 36 visits within the first 90 consecutive calendar days of therapy. For MHP enrollees, the provider should check with the MHP for prior authorization requirements.

For physical therapy services, use revenue 42X series with the appropriate CPT/HCPCS code **on the claim line**. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity. The fee screen for physical therapy includes all services. The hospital **cannot** bill a clinic room charge in addition to the therapy, unless the visit is unrelated to physical therapy.

Medicaid covers the physical therapy evaluation/reevaluation twice in a 365-day period. Report revenue code 0424 with CPT/HCPCS code 97001 "evaluation" or 97002 "reevaluation" with a quantity of "1." Evaluation or reevaluation cannot be paid when it is billed with other physical therapy services on the same day. Therapy must be provided by the evaluating discipline.

Prior authorization is required for continuing therapy beyond the initial 90 days therapy.

Physical therapy may be series billed.

## SPEECH-LANGUAGE THERAPY

Speech-language therapy does not require prior authorization for a maximum of 36 visits within the first 90 consecutive calendar days of therapy. For MHP enrollees, the provider should check with the MHP for prior authorization requirements.

Speech therapy must be billed with the 44X series Revenue Codes along with the appropriate CPT/HCPCS code **on the claim line**. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity.

Therapy must be provided by the evaluating discipline. Medicaid covers the speech pathology evaluation/reevaluation without prior authorization twice in a 365-day period. Report revenue code 0444

with CPT/HCPCS code 92506 with quantity of “1”. Evaluation or reevaluation **cannot** be paid when it is billed with other speech pathology services on the same day. Speech pathology may be series billed.

The fee for speech-language therapy includes all services. The hospital **cannot** bill a clinic room charge in addition to the therapy, unless the visit is unrelated to speech therapy.

Prior authorization is required for continuing therapy beyond the initial 90 days of therapy.

Speech therapy for beneficiaries under age of 21 **must be provided** and billed by hearing speech centers (Provider Type 80).

## ULTRASONOGRAPHY

When billing two ultrasound codes, the diagnosis must reflect the medical need for two procedures.

Claims for diagnostic ultrasound procedures that are performed more than once must be documented for medical necessity. Documentation with the claim should clearly state the **reason** for the repeat procedure (e.g. multiple gestation, breach presentation, pre-term labor, etc.). Claims will be rejected if the documentation does not support the medical necessity for the repeat diagnostic procedure.

## WEIGHT REDUCTION

**Billing Instructions:**

- A copy of the letter of authorization for the weight reduction that was sent to the attending physician from the Office of Medical Affairs must be submitted with the claim.
- Indicate ”prior authorization letter submitted” in the Remarks Section.

## REVENUE CODES AND CPT/HCPCS CODES

These revenue codes require CPT/ HCPCS code on the **claim line.**

0280 Oncology
0289 Oncology/Other
0300 Laboratory/Clinical
0301 Lab/Chemistry
0302 Lab/Immunology
0303 Lab/Renal Patient (Home)
0304 Lab Non-routine Dialysis
0305 Lab Hematology
0306 Lab/Bacteriology and Microbiology
0307 Lab/Urology
0309 Lab/Other
0310 Laboratory/Anatomical
0311 Lab/Cytology
0312 Lab/Histology
0314 Lab/Biopsy
0319 Lab/Other
0320 Radiology/Diagnostic
0321 Radiology/Angiocardiography
0322 Radiology/Arthrography
0323 Radiology/Arteriography
0324 Radiology/Chest X-ray
0329 Radiology/ Digital Subtraction Angiography
0330 Radiology/Therapeutic
0333 Radiation Treatment
0339 Radiology/Other
0340 Nuclear Medicine
0341 Nuclear Medicine/Diagnostic
0342 Nuclear Medicine/Therapeutic
0349 Nuclear Medicine/Other
0350 CT Scan/Head
0351 Head Scan
0352 Body Scan
0359 CT Scan/Other
0361 OR/Minor
0400 Imaging Services
0401 Diagnostic Mammography
0402 Ultrasound
0403 Screening Mammography
0404 Positron Emission Tomography
0409 Imaging Services/Other
0420 Physical Therapy
0421 Physical Therapy/Visit
0422 Physical Therapy/Hourly
0423 Physical Therapy/Group
0424 Physical Therapy/Evaluation
0429 Physical Therapy/Other
0430 Occupational Therapy
0431 Occupational Therapy/Visit, regardless of time
0432 Occupational Therapy/Hour
0433 Occupational Therapy/Group, regardless of time
0434 Occupational Therapy/Eval
0439 Occupational Therapy/Other
0440 Speech Pathology
0441 Speech Pathology/Visit
0442 Speech Pathology/Hourly, 30-60 minutes
0443 Speech Pathology/Group
0444 Speech Pathology/Eval
0449 Other Speech Path
0460 Pulmonary Function
0469 Pulmonary Function/Other
0470 Audiology
0471 Audiology/Diagnostic
0472 Audiology/Treatment
0479 Audiology/Other
0480 Cardiology
0482 Stress Test
0483 Echocardiology
0489 Cardiology/Other
0513 Clinic/Psychiatric (PT 21 only)
0519* Clinic/Other
0610 MRT
0611 MRI – Brain
0612 MRI – Spinal Cord
0614 MRI-Other
0615 MRA-Head and Neck
0616 MRA-Lower Ext
0618 MRA- Other
0619 MRT- Other
0631 Single Source Drug
0632 Multiple Source Drug
0634 Erythropoeitin less than 10,000 units
0635 Erythropoeitin greater than 10,000 units
0636 Drugs Requiring Detailed Testing
0730 EKG/ECG
0731 Holter monitor
0732 Telemetry
0739 Computerized EKG/ECG

0740 EEG
0749 Other EEG
0771 Vaccine Administration
0855 CCPD/Home/Supserv
0900 Psychiatric/Psychological Treatments Imaging
0901 Electroshock Treatment
0902 Milieu Therapy
0903 Play Therapy
0909 Psychiatric/Psychological Other
0910 Psychiatric/Psychological Services
0911 Rehabilitation
0914 Individual Therapy
0915 Group Therapy
0916 Family Therapy
0918 Psychiatric/Testing
0919 Psychiatric/Other
0920 Other Diagnostic Services
0921 Peripheral Vasular Lab
0922 Electromyelogram
0923 Pap smear
0924 Allergy Test
0925 Pregnancy Test
0929 Other Diagnostic Services
0940 Other Therapeutic Services

These revenue code require CPT/HCPCS code on the **claim.**

0250 Pharmacy
0251 Drugs/Generic
0252 Drugs/Non-Generic
0254 Drugs/Incident Other Dx
0255 Drugs/Incident Radiology
0257 Drugs/Non-Script
0258 IV Solutions
0259 Drugs/Other
0260 IV Therapy
0262 IV Therapy/Pharm/SVC
0263 IV Therapy/Drug/Supply
0264 IV Therapy/Supplies
0269 IV Therapy/Other
0270 Med-Surg-Supplies
0271 Non-Sterile Supply
0272 Sterile Supply
0274 Prosth/Orth Device
0275 Pacemaker
0276 Intra-Occular Lens
0278 Supply/Implants
0279 Supply/Other
0331 ChemoTher/Inj.
0335 Chemo Ther/IV
0360 OR Services
0369 OR/Other
0370 Anesthesia
0371 Anesthesia/Incdnt Rad
0372 Anesthesia/Incdnt Other
0379 Anesthesia/Other
0380 Blood
0381 Blood/Packed Red Cells
0382 Blood/Whole
0383 Blood Plasma
0384 Blood Platelets
0385 Blood Leucocytes
0386 Blood Components
0387 Blood Derivatives
0389 Blood/Other
0390 Blood/Stor-Proc
0391 Blood/Admin
0399 Blood/Other Stor
0410 Respiratory Service
0412 Inhalation Service
0413 Hyperbaric O2
0419 Other Respiratory Service
0450 Emergency Room
0451 EMTALA Emergency Medical Screening Services
0456 Urgent Care
0481 Cardiac Cath Lab
0621 Med-Surg/Supp/Incdnt Rad
0623 Surgical Dressings
0700 Cast Room
0709 Other Cast Room
0710 Recovery Room
0719 Other Recovery Room
0750 Gastro-Intestinal Services
0759 Other Gastro-Inst
0762 Observation Room
0790 Lithotripsy
0799 Lithotripsy/Other

## MINOR SURGERY/ PROCEDURE

These CPT/HCPC codes must be billed with Revenue Code **0361.**

| | | | | | |
|---|---|---|---|---|---|
| 10040 | 11983 | 29125 | 40800 | 53660 | 65210 |
| 10060 | 16020 | 29126 | 40804 | 53661 | 65220 |
| 10080 | 16025 | 29130 | 40806 | 54055 | 65222 |
| 10120 | 16030 | 29131 | 40808 | 54056 | 65430 |
| 10140 | 17000 | 29200 | 40810 | 54057 | 65435 |
| 10160 | 17003 | 29220 | 40812 | 54060 | 65436 |
| 11000 | 17004 | 29240 | 40820 | 54065 | 65450 |
| 11040 | 17106 | 29260 | 41000 | 54100 | 67345 |
| 11041 | 17110 | 29280 | 41005 | 54200 | 67700 |
| 11100 | 17111 | 29345 | 41010 | 54235 | 67800 |
| 11101 | 17260 | 29355 | 41015 | 54240 | 67801 |
| 11200 | 17261 | 29358 | 41110 | 54500 | 67805 |
| 11201 | 17270 | 29365 | 41800 | 54800 | 67810 |
| 11300 | 17271 | 29405 | 41805 | 55000 | 67820 |
| 11301 | 17280 | 29425 | 41850 | 55200 | 67825 |
| 11302 | 17340 | 29435 | 42160 | 55250 | 67840 |
| 11303 | 17360 | 29440 | 42280 | 55450 | 67850 |
| 11305 | 17380 | 29445 | 42400 | 56501 | 67915 |
| 11306 | 17999 | 29450 | 42804 | 56605 | 67922 |
| 11310 | 19000 | 29505 | 43760 | 56606 | 67938 |
| 11311 | 19001 | 29515 | 46050 | 56720 | 68020 |
| 11400 | 20500 | 29520 | 46083 | 57020 | 68040 |
| 11401 | 20520 | 29530 | 46220 | 57061 | 68100 |
| 11402 | 20550 | 29540 | 46221 | 57100 | 68110 |
| 11420 | 20600 | 29550 | 46230 | 57160 | 68115 |
| 11421 | 20605 | 29580 | 46320 | 57170 | 68135 |
| 11440 | 20610 | 29700 | 46500 | 57452 | 68200 |
| 11441 | 20615 | 29705 | 46600 | 57454 | 68400 |
| 11600 | 20665 | 29710 | 46604 | 57460 | 68440 |
| 11620 | 20670 | 29715 | 46606 | 57500 | 68705 |
| 11640 | 23330 | 29720 | 46608 | 57505 | 68760 |
| 11720 | 24065 | 29730 | 46910 | 57510 | 68761 |
| 11721 | 24200 | 29740 | 46916 | 57511 | 68801 |
| 11730 | 25065 | 29750 | 46917 | 57513 | 68810 |
| 11732 | 26010 | 29799 | 46935 | 57800 | 68840 |
| 11740 | 27040 | 30020 | 51000 | 58100 | 69000 |
| 11755 | 27086 | 30100 | 51700 | 58300 | 69100 |
| 11900 | 27323 | 30110 | 51705 | 58301 | 69105 |
| 11901 | 27613 | 30124 | 51725 | 58350 | 69145 |
| 11950 | 28001 | 30200 | 51726 | 59020 | 69200 |
| 11951 | 28190 | 30300 | 51736 | 59025 | 69420 |
| 11952 | 29049 | 31000 | 51784 | 62252 | 69424 |
| 11954 | 29055 | 36415 | 51785 | 62367 | 69433 |
| 11975 | 29058 | 36470 | 51792 | 62368 | 96910 |
| 11976 | 29065 | 36471 | 53600 | 64612 | 96912 |
| 11977 | 29075 | 38300 | 53601 | 64613 | 96920 |
| 11981 | 29085 | 38505 | 53620 | 64614 | 96921 |
| 11982 | 29105 | 40490 | 53621 | 65205 | 96922 |

## INTERVENTIONAL RADIOLOGY SERVICES

These CPT/HCPC codes support Interventional Radiology services (Revenue Code 0369).

| | | | | | |
|---|---|---|---|---|---|
| 70010 | 74185 | 75660 | 75805 | 75900 | 76360 |
| 70015 | 74300 | 75662 | 75807 | 75940 | 76390 |
| 70170 | 74301 | 75665 | 75809 | 75945 | 76930 |
| 70373 | 74320 | 75671 | 75810 | 75946 | 76932 |
| 70390 | 74350 | 75676 | 75820 | 75960 | 76941 |
| 71040 | 74355 | 75680 | 75822 | 75961 | 76942 |
| 71060 | 74360 | 75685 | 75825 | 75962 | 76945 |
| 71090 | 74425 | 75705 | 75827 | 75964 | 76946 |
| 71555 | 74430 | 75710 | 75831 | 75966 | 77750 |
| 72240 | 74440 | 75716 | 75833 | 75968 | 77761 |
| 72255 | 74445 | 75722 | 75840 | 75970 | 77762 |
| 72265 | 74450 | 75724 | 75842 | 75978 | 77763 |
| 72270 | 74455 | 75726 | 75860 | 75980 | 77776 |
| 72275 | 74470 | 75731 | 75870 | 75982 | 77777 |
| 72285 | 74475 | 75733 | 75872 | 75984 | 77778 |
| 72295 | 74480 | 75736 | 75880 | 75989 | 77781 |
| 73040 | 74740 | 75741 | 75885 | 75992 | 77782 |
| 73085 | 75600 | 75743 | 75887 | 75993 | 77783 |
| 73115 | 75605 | 75746 | 75889 | 75994 | 77784 |
| 73525 | 75625 | 75756 | 75891 | 75995 | 77789 |
| 73542 | 75630 | 75774 | 75893 | 75996 | 77790 |
| 73580 | 75635 | 75790 | 75894 | 76080 | 78494 |
| 73615 | 75650 | 75801 | 75896 | 76086 | 78496 |
| 73725 | 75658 | 75803 | 75898 | 76088 | |

## REVENUE CODE AND REIMBURSEMENT GROUPS

Charges for each group of the following revenue codes will be accumulated and reimbursed a single fee or the total charge, whichever is less. The amount approved for the first revenue code billed in the group will equal the lesser of the charge or fee for the group. Subsequent claim lines for revenue codes in the group will reflect an amount approved equal to the lesser of the charge or balance of the fee. **Exception:** the revenue codes in group "D," will be paid a percent of charges if provided in conjunction with a supporting HCPCS code in F.L. 44 and Revenue Codes 0360, 0369, or 0481 also reported on the claim.

**Group A**

0250 Pharmacy
0251 Drugs/Generic
0252 Drugs/Non-Generic
0254 Drugs/Incdnt Other Dx
0255 Drugs/Incdnt Rad
0257 Drugs/Non-Generic
0259 Drugs/Non-Script

**Group B**

0258 IV Solutions
0262 IV Ther/Pharm/Svc
0263 IV Ther/Drug/Supp
0269 IV Therapy/Other

**Group C**

0260 IV Therapy
0331 Chemo Ther/Inj
0335 Chemo Ther/IV
0700 Cast Room
0709 Other Cast Room
0750 Gastro-Inst Svs
0759 Other Gastro-Inst

**Group D**

0264 IV Ther/Supplies
0270 Med-Surg/Supplies
0271 Non-Ster Supply
0272 Sterile Supply
0274 Prosth/Orth Dev
0275 Pacemaker
0276 Intra-Oc Lens
0278 Supply/Implants
0279 Supply/Other
0621 Med-Sur Supp/Incdnt Rad
0623 Surgical Dressings

**Group E**

0360 OR Services
0369 OR/Other
0481 Cardiac Cath Lab

**Group F**

0370 Anesthesia
0371 Anesth/Incdnt Rad
0372 Anesth/Incdnt Other
0379 Anesth/Other

**Group G**

0380 Blood
0381 Blood/Pkd Red
0382 Blood/Whole
0383 Blood/Plasma
0384 Blood/Platelets
0385 Blood/Leucocytes
0386 Blood/Components
0387 Blood/Derivatives
0389 Blood/Other
0390 Blood/Stor-Proc
0391 Blood Admin
0399 Blood/Other Stor

**Group H**

0410 Respiratory Svc
0412 Inhalation Svc
0413 Hyperbaric O2
0419 Other Respir Svc

**Group J**

0456 Urgent Care
0510 Clinic
0511 Chronic Pain Clinic
0514 OB-GYN Clinic
0515 Peds clinic
0516 Urgent Care clinic
0517 Family Practice
0760 Treatment/Observ
0761 Treatment Room
0769 Other Treatment Room
0770 Preventive Care/Genera
0779 Other Preventive Care Services

**Group K**

0710 Recovery Room
0719 Other Recovery Rm

**Group L**

0720 Delivery Room/Labor
0721 Labor
0722 Delivery Room
0724 Birthing Center

**Group M**

0820 Hemo/OPOR Home
0821 Hemo/Composite
0825 Hemo/Home/Sup. Service
0829 Hemo/Home/Other
0830 Peritoneal/Op or Home
0831 Pertnl/Composite
0835 Peritoneal/Home/ Sup. Serv
0839 Peritoneal/Home Other

**Group N**

0840 CAPD/OP OR Home
0841 CAPD/Composite
0845 CAPD/Home/ Sup. Service
0849 CAPD/Home/Other
0850 CCPD/OP OR Home
0851 CCPD/Composite
0859 CCPD/Home/Other

## GENERAL INFORMATION

The information in this section should be used in conjunction with the Uniform Billing Manual when preparing nursing facility claims.

## 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, along with 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 Healthcare Common Procedure Coding System manual.

| DESCRIPTION | REVENUE CODES | CPT |
|---|---|---|
| Physical Therapy | 0420, 0424, 0429 | 95851, 95852, 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 |
| Occupational Therapy | 0430, 0434, 0439 | 97003, 97004, 95851, 95852, 97016, 97018, 97022, 97034, 97035, 97110, 97112, 97124, 97504, 97530, 97535, 97799 |
| Speech Pathology | 0440, 0443, 0444, 0449 | 92506, 92507, 92508 92526, 92597, 92610 |

## 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.

## 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 the Patient Status as "03", Discharged/transferred to SNF.

- the second facility must indicate "05", Transfer from a SNF, as the Source of Admission, 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 the Value Code Amount 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 the Value Code Amount and the Value Code must be D3. An explanation of the need for the replacement claim must be entered in the Remarks.

## HOSPITAL LEAVE DAYS

Hospital leave days are limited to a total of 10 days per admission to the hospital for emergency medical treatment. The patient must return to the nursing facility in ten or fewer days in order for the nursing facility to bill for hospital leave days. When billing, the facility must use:

- Revenue Code 0185 and
- Occurrence Span Code 74, 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, 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 on the claim. In the event a beneficiary is approved for both an MOU and therapy services, one prior authorization number will be issued for both the MOU and therapy. 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 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 **From Date** and **Through Date**, 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 that are exempt from the DRG system may bill for Medicaid covered swing bed days beginning the day of admission to the swing bed.

- The **Units of Service** entered 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 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 on the claim.

**Note:** When billing, the facility must enter on the claim the nine-digit prior authorization number listed on the Medicaid authorization letter. In the event a beneficiary is approved for both an MOU and therapy services, **one** prior authorization number will be issued for both the MOU and therapy.

## 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.

## 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.

## COST SETTLED PROVIDER DETAIL REPORT (FD-622)

The Medicaid Program sends each nursing facility a Cost Settled Provider Detail Report (FD-622). The FD-622 is designed to provide detailed information of a facility's charges paid by Medicaid. Since Medicaid acts as a fiscal agent for many different sources of payment, the FD-622 includes all of these sources.

This report is an excellent accounting tool when maintained and used properly. It can be used in conjunction with the Remittance Advice to reconcile the accounts receivable. More important, the FD-622 can be used as the actual log that the facility must maintain for Medicaid. This should eliminate duplication of paperwork by the facility.

For the most part, the FD-622 includes Medicaid Payroll information, facility's Medicaid billing information, the facility's current interim reimbursement rate; indicator if the facility is on Medicaid Interim Payments, beneficiary information on services billed to Medicaid, summary of cost settled services, total charges billed to Medicaid, amount paid by other Medicare/other insurance/beneficiary, Medicaid payments, gross adjustments, Medicaid claim statistic information.

The detail portion of the FD-622 will not print unless there were paid services for a facility for that week.

## GENERAL INFORMATION

The information in this section should be used in conjunction with the Uniform Billing Manual when preparing home health claims.

## INTERMITTENT NURSING VISITS/AIDE VISITS/THERAPIES

**Billing Instructions:**

- Each visit must be reported on a separate claim line
- Medicaid follows Medicare policy on the requirement that each home health agency visit (e.g., nursing, therapy) must be billed on an individual line. This policy includes two visits performed on the same day (i.e., two visits on the same day must be billed on individual lines).
- 15 - Minute Increment Reporting

  Medicaid follows Medicare policy on the requirement that home health agencies must report home health visits in 15-minute increments. When billing, each home health visit revenue code that is reported, must have a corresponding 15-minute increment HCPCS code along with the number of 15-minute increments reported in the Service Units.

  Reported visits are to be rounded to the nearest 15-minute increment. Rounding off to the nearest 15-minutes must be reported as follows:

| Units | |
|---|---|
| 1 | 1 minute to < 23 minutes |
| 2 | 23 minutes to < 38 minutes |
| 3 | 38 minutes to <53 minutes |
| 4 | 53 minutes to <68 minutes |
| 5 | 68 minutes to <83 minutes |
| 6 | 83 minutes to <98 minutes |
| 7 | 98 minutes to < 113 minutes |
| 8 | 113 minutes to < 128 minutes |

If services continue for longer periods of time, the home health agency would follow the above pattern.

**Time of Service Visit:** The timing of the visit begins at the beneficiary's home when services actively begin and end when services are completed. The time counted must be the time spent actively treating the beneficiary.

**Examples:**

- If a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than 3 minutes), then the time the beneficiary spends on the telephone and not engaged in treatment does not count in the amount of service.
- The home health aide completed bathing and transferring the beneficiary into a chair, and now begins to wash the kitchen dishes before leaving. Washing the dishes is considered incidental and does not meet the definition of a home health aide service. Therefore, the time to perform this activity would not be included in the 15-minute incremental reporting to Medicaid.

Other non-treatment related interruptions would follow the same principle. If the beneficiary is late returning home from a doctor's appointment, the waiting time of the home health agency personnel also cannot be counted as treatment time.

However, if the professional spends time with family or other caretakers in the home teaching them to care for the beneficiary, this activity **is** counted as treatment time. If the nurse calls the physician to report on the beneficiary's condition while in the beneficiary's home, this can also be counted as treatment time.

**Note:** If beneficiary assessment activities for completion of the OASIS data set are a part of an otherwise covered and billable visit, time spent in beneficiary assessment may be included in the total count of 15-minute increments. The completion of the assessment activities must be incorporated into a visit providing otherwise necessary home health care to the beneficiary. A separate visit made only to collect information for the OASIS assessment, but not to provide other covered home health services, would not be billable.

## POSTPARTUM/NEWBORN FOLLOW-UP NURSE VISIT

- Medicaid allows one (1) *initial* postpartum and one (1) *initial* newborn visit per pregnancy. The initial postpartum visit must be billed using the mother's Medicaid ID#. The initial newborn visit must be billed using the newborn's Medicaid ID#.
- Medicaid allows one (1) *subsequent* visit to the mother and newborn. This subsequent visit may be billed under either the mother's ID# or newborn's ID#, based on which beneficiary the nurse spent the majority of the time.

## BLOOD LEAD POISONING NURSING ASSESSMENT/INVESTIGATION VISITS

Coverage is limited up to two (2) visits per episode per child diagnosed with blood lead poisoning. If more than one child in the home has blood lead poisoning, nurse education visits may be billed for each child. As with other home health services, this service must be ordered by the beneficiary's physician.

These services must be billed as a nurse visit.

- Use Revenue Codes 0550, 0551 or 0552,
- HCPCS code of G0154,
- Applicable ICD-9 CM diagnosis code of 9840, 9841, 9848, or 9849.

## HOME HEALTH PROCEDURE CODES

When billing, the home health agency must use the HCPCS codes are located in the Health Care Financing Administration Common Procedure Coding System manual and the Revenue Codes in the UB Manual.  Providers should refer to the Home Health Fee Screen on the MDCH website for a listing of covered Revenue and HCPCS Codes.

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## GENERAL INFORMATION

The information in this section should be used in conjunction with the Uniform Billing Manual when preparing private duty nursing agency claims.

## BILLING INSTRUCTIONS

The following should be noted:

- Each month must be billed on a separate claim.
- Each date of service must be reported on a separate claim line.
- Each claim line must report the number of hours of care in the Days or Units item for that date of service.
- The prior authorization number listed on the Medicaid authorization letter must be recorded on the claim.
- The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.
- A plan of care **is not** to be attached to the claim or otherwise submitted to the Medicaid program unless specifically requested to do so by the program.
- The **total** number of hours reported **must not** exceed the total hours that were authorized for that month.
- Since whole hours of care are authorized, only those hours of care that entail **a full hour** of care may be billed.
- Adjustments to claims are made through a total claim replacement or void/cancel process.

### MULTIPLE BENEFICIARIES SEEN AT SAME LOCATION

The specific procedure codes listed in this section must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These procedure codes must be used for **each** beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, as approved, the multiple beneficiary code must be used for both children. The total Medicaid reimbursement for multiple beneficiaries will be time-and-one-half for two beneficiaries.

## REVENUE CODES/HCPCS CODES/MODIFIERS

When billing, the provider must use the following codes. The HCPCS Codes/Modifiers are located in the Health Care Financing Administration Common Procedure Coding System manual.

| Description | Revenue Code | HCPCS Code/Modifier |
|---|---|---|
| Nursing Care, RN, Per Hour | 0582 | S9123 |
| Nursing Care, RN, Per Hour, Holiday | 0582 | S9123 |
| Nursing Care, LPN, Per Hour | 0582 | S9124 |
| Nursing Care, LPN, Per Hour, Holiday | 0582 | S9124 |
| Nursing Care, 1 RN to 2 Patients, Per Hour | 0582 | S9123 TT |
| Nursing Care, 1 RN to 2 Patients, Per Hour, Holiday | 0582 | S9123 TT |
| Nursing Care, 1 LPN to 2 Patients, Per Hour | 0582 | S9124 TT |
| Nursing Care, 1 LPN to 2 Patients, Per Hour, Holiday | 0582 | S9124 TT |
| For ratios of more than 2 patients per nurse, the provider must contact the patient's case manager at the Children's Special Health Care Services (CSHCS), Home and Community-Based Services Waiver for the Elderly and Disabled, Children's Waiver (CMHSP), or Habilitation/Support Services Waiver (CMHSP). These ratios are considered exceptional cases and require prior approval. | | |

## GENERAL INFORMATION

The information in this section should be used in conjunction with the Uniform Billing Manual when preparing hospice claims.

## BILLING INSTRUCTIONS

Special instructions for Hospice claim completion:

- **Admission Date:** Include the admission date for hospice care.
- **Inpatient Respite care:** "Occurrence Span Code" include occurrence span code M2 and complete the "from and through" dates for an episode of inpatient respite care.
- **Metropolitan Statistical Area (MSA):** "Value Codes" include value code "61" in value code field. Additionally, report the MSA (Metropolitan Statistical Area) number followed by two zeros.

Use the Revenue Codes in the table below.

| Revenue Code | Description |
|---|---|
| 0650 | General I |
| 0651 | Routine Home Care I |
| 0652 | Continuous Home Care |
| 0655 | Inpatient Respite Care |
| 0656 | General Inpatient Care |
| 0657 | Physician Services |
| 0658 | Other Hospice I |

- To bill for room and board in a nursing home or licensed hospice long term care unit, use revenue code 0658. Providers are to bill their customary Room & Board rate and Medicaid will pay the usual and customary rate, or the Medicaid fee screen, whichever is less.
- To bill the pharmacy co-pay for Medicare-Medicaid eligible beneficiaries, use revenue code 0650 “General.”
- Revenue Code 0657 “Physician Services” requires a HCPCS code be included on the claim line. Each physician service must be billed on a separate claim line.
- Revenue Code 0652 “Continuous Home Care” must be billed for each date of service on separate claim lines.
- Hospital Leave Days must be billed using revenue code 0185 (must not exceed 10 consecutive days). Reimbursement will be at 95% of Nursing Facility rate for leave days
- Therapeutic Leave Days must be billed using Revenue Code 0183 (must not exceed 18 total days for the year). Reimbursement will be at 95% of Nursing Facility rate for leave days.

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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 a **7 (xx7)** as the third digit "frequency".

The provider must enter in the 10-digit Claim Reference Number of the **last** approved claim being replaced.

The provider must enter in Remarks the reason for the replacement.

## VOID/CANCEL 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 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 Remarks the reason for the void/cancel.

**Note:** A void/cancel claim must be completed **exactly** as the original claim.

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

## REFUND OF PAYMENT

Providers may refund payments to the MDCH when the entire amount for a claim needs to be returned due to overpayment, either from a third-party resource or due to an error. A copy of the RA with a check made-out to the "State Of Michigan" in the amount of the refund should be sent to:

MDCH/ Cashier unit
P. O. Box 30437
Lansing, MI 48909

Use of the replacement claim or the void/cancel claim is the preferred method of refunding **the entire amount of a previously paid claim.**

**Note: DO NOT** submit both a replacement claim or a void/cancel claim **AND** manually send a refund to the Cashier's Unit as this will result in an incorrect refund amount.

## PAYMENTS/CLAIM STATUS

The MDCH processes claims and issues payments (by check or electronic funds transfer [EFT]) every week unless special provisions for payments are included in your enrollment agreement. A Remittance Advice (RA) is issued with each payment 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, no action is taken on previously pended claims, or no payment gross adjustments are processed in the pay cycle, an RA is not generated.

If the total amount approved for claims on any one RA is less than $5.00, a payment 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 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.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with the MDCH under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from the MDCH through EFT must register through the Department of Management and Budget's (DMB) website. See the Directory Appendix for DMB website information.

## REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. The RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. See the Directory Appendix for contact information.

### HEALTH CARE CLAIM PAYMENT/ADVICE (ELECTRONIC RA)

The electronic RA is produced in the HIPAA-compliant health care claim payment/advice (ANSI X12N 835 version 4010A1) format. Providers opting to receive an electronic RA will receive all information regarding adjudicated (paid or rejected) claims in this format. Information regarding pended claims will be reported electronically in the 277 Unsolicited Claim Status format.

The 835 has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems
- It includes a MDCH trace number to identify the associated warrant or electronic funds transfer (EFT) payment
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim
- It contains additional informational fields not available on the paper RA

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle will report on a single 835 and/or 277U, regardless of how the claims were submitted (e.g. some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835/277U transaction must identify a primary service bureau to receive the 835/277U. All providers under the same corporate TIN must utilize the same primary service bureau. An addition of and/or change to the identification of the primary service bureau must be submitted to Provider Enrollment. The primary service bureau will be the only one to receive the 835/277U remittance information for all claims regardless of submission source. No other service bureau submitting claims for that provider/group TIN will receive information regarding claims submitted.

For more information regarding the 835 and 277U transactions issued by the MDCH, refer to the MDCH Companion Guides on the department's website. For general information about the 835 and 277U, refer to the Implementation Guides for these transactions. The Implementation Guides are available through the Washington Publishing Company. See the Directory Appendix for contact information.

## PAPER RA

All providers with adjudicated or pended claims will receive a paper RA, even if they opt to receive the 835/277U transactions.

**Paper RA Header:** The following information is supplied on the paper RA header.

- Provider ID No. and Provider Type: This is the Medicaid 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# 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 and the Michigan Department of Treasury. Incorrect information should be reported to the Provider Enrollment Unit. (See the Directory Appendix for contact 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:** The following information is supplied on the paper RA claim header

- **Patient ID Number:** Prints the beneficiary's Medicaid ID number that the provider entered on the claim.

- **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 are the Julian Date the claim was received by MDCH. The fifth through tenth digits are the sequential claim number assigned by the MDCH.

  Example: In CRN 3223112345, 3 is the year 2003, 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 following by a two-character input ID (3223223445-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 (admit date for inpatient service).
- **Procedure Code:** This identifies the procedure code or 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 for the entire claim.
- **Amount Approved:** This identifies the amount the MDCH approved for the service line (amount approved for DRG represents the entire claim and it is not approved by claim line). Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from MDCH. For example, when other resources made a payment greater than MDCH's usual payment.
- **Claim Adjustment Reason Code:** Claim adjustment reason codes communicate why a claim or service line was paid differently than was billed. If there is no adjustment to a claim line, then there is no adjustment reason code.
- **Claim Remark Code:** Claim remark codes relay service line-specific information that cannot be communicated with a reason code.
- **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.
- **Page Total:** This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two PA 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 hospitals and 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 the 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 RA.

The paper RA will indicate gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes will be used. Code definitions can be found in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDCH gross adjustment code that corresponds to the gross adjustment description.
  - 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.
- **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 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 or EFT 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 Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid, rejected, or pended and lists edits that apply.

**Rejections:** If a service line is rejected, a Claim Adjustment Reason/Remark code will print in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definitions of the codes to determine the reason for the rejection.

**Pends:** If any service line pends for manual review, PEND prints in the Claim Adjustment Reason/Remark 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, the 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.

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 # 2351203770-59
2 = year of 2002
351 = Julian date for December 17
203770 = consecutive # of invoice
59 = internal processing

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