MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Home Health Agencies 03-08
Private Duty Nursing Agencies
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Issued: October 1, 2003

Subject:
- Correction to New Institutional Billing and Reimbursement Chapter IV
- Offset to Patient-Pay Amount for Non-Covered Services – Billing Instructions

Effective: October 1, 2003

Programs Affected: Medicaid

Correction to New Institutional Billing and Reimbursement Chapter IV

This bulletin is to notify providers of a correction to the New Institutional Billing and Reimbursement Chapter IV, sent under MSA Bulletin 03-14, issued August 1, 2003.

Page 1, first paragraph, last sentence of MSA Bulletin 03-14 reads: "The policies and instructions contained in the chapter are effective for dates of service on or after October 1, 2003." Please make a pen and ink change to this sentence by replacing the sentence with the following: "The policies and instructions contained in the chapter are effective for all claims received on or after October 1, 2003."

Offset to Patient-Pay Amount for Non-Covered Services – Billing Instructions

As of October 1, 2003, Medicaid All Provider Bulletin 03-09 stated that Medicaid would no longer cover chiropractic, podiatry, hearing aid dealer, and dental (other than emergency dental or oral surgery) services for beneficiaries age 21 or older. The Medicare Catastrophic Act of 1988 allows nursing facility beneficiaries to access their patient-pay amount to pay for necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program.

Nursing Facilities

All Provider Bulletin 03-09 stated that Medicaid would provide billing information regarding offsets to the patient-pay amount. This bulletin contains those instructions. These instructions are for dates of service on and after October 1, 2003.

Hospice Agencies

Because offset to the patient-pay amount affects hospice agencies that are providing services to beneficiaries residing in a nursing facility, this bulletin contains the billing instructions for the hospice. These instructions are for dates of service on and after October 1, 2003.

Hospice agencies are reminded that if a hospice beneficiary is in a nursing facility, it is the hospice's responsibility to collect the patient–pay amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

Prior Approval

All Provider Bulletin 03-09 and Nursing Facility Bulletin 02-02 stated that prior approval must be obtained from Medicaid to offset the patient-pay amount. *This requirement has been lifted.* The nursing facility or hospice do not need to obtain prior authorization to offset the patient-pay amount.

Appointment with Ancillary Provider/Fiscal Record

The beneficiary or beneficiary's representative may choose to purchase non-covered services directly from an ancillary provider. The beneficiary pays the ancillary provider directly for the services provided.

The nursing facility and hospice agency must retain, in the beneficiary's fiscal record, receipts showing that the beneficiary paid for the particular non-covered service. Medicaid post-payment reviews will be conducted to assure that the beneficiary's fiscal record contains the receipts.

Billing Instructions

Claims containing an offset to the patient-pay amount cannot be split-billed. The facility and hospice must submit one claim for the particular month of service.

The offset for the non-covered service must be reported on the claim using the appropriate Value Code in F.L. 39 and the related dollar amount. New Value Codes were approved by the National Uniform Billing Committee (NUBC) on September 17, 2003 and are available on the NUBC website www.nubc.org. Only value codes for Michigan Medicaid non-covered services will be activated for approval through the claims processing system.

The dollar amount of Value Code D3 - Estimated Responsibility Patient (Patient-Pay Amount) is the beneficiary's monthly patient-pay amount MINUS the dollar amount of the offset.

The total of D3 and the offset must equal the beneficiary's patient–pay amount for that given month.

Offsetting the patient-pay amount may involve more than one month. For example, the beneficiary may have a patient-pay amount of $200 per month. The amount to be offset is $500. The amount to be offset would involve a three-month period. The first month claim would indicate $200 as an offset with D3 as zero. The second month claim would show $200 as an offset with D3 as zero. The third month claim would show $100 as an offset with D3 as $100.

Manual Maintenance

The above information will be incorporated in the Medicaid Manual in the near future. Until the information is added, providers are to retain this bulletin.

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

Paul Reinhart, Director
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