Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

CONSULTEC

600 Seventeenth Street
Suite 600 North
Denver, CO 80202

Medicaid Provider Services

303-534-0146
1-800-237-0757

Mailing Addresses

Claims & PARs
P.O. Box 30
Denver, CO 80201-0030

Correspondence, Inquiries & Adjustments
P.O Box 90
Denver, CO 80201-0090

Provider enrollment, Provider information, Changes, Signature authorization, and Claim requisitions
P.O. Box 1100
Denver, CO 80201-1100

Medicaid Fiscal Agent Information on the Internet

coloradomedicaid.consultec-inc.com

Medicaid bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medicaid Provider Manual and should be retained with the provider manual for reference. Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.

Please direct questions about bulletins and billing information to Medicaid Provider Services.

Distribution: Hospital providers **September 2000**

Reference: B0000075

Contents

New Edits

Effective August 1, 2000, two new edits were added to the Medicaid claims processing system. The two edits primarily affect claims for newborns using the mother's State ID number.

Edit **0272**	The admit date on the claim is prior to the client's date of birth.
Edit **0273**	The claim DRG indicates newborn. Client is not considered a newborn.

Claims are denied with edit 0272 if the admission date is prior to the date of birth on the claim.

Claims are denied with edit 0273 if the client is not a newborn and the provider is billing with a neonatal DRG. Claims should be billed using the client's ID and the appropriate DRG.

Replacement pages for Appendix N, Remittance Statement/Denial Messages and Explanations will be included with a future bulletin.

Maternity and newborn billing

Do not show nursery days in FLs 6, 7, or 8. Nursery days are entered as units on a detail line but are not covered days that represent additional payment.

There is no additional inpatient benefit for routine newborn hospitalization. However, benefits are paid for a newborn client when the newborn requires additional hospitalization due to a medical condition. Medicaid benefits are provided for an eligible newborn client whose mother is not enrolled in the Medicaid program. Charges for a **well** newborn remaining in the hospital after the mother's discharge (e.g., placement) are not a benefit.

Mother in Hospital

- ✓ Mother and baby's charges are combine billed on one claim as one stay.
- ✓ Baby is transferred to a different hospital and becomes a patient in its own right. The baby requires its own State ID number. The baby's charges must be billed separately by the receiving hospital.

Mother is Discharged

- ✓ Baby remains in hospital *for placement.* This is not a Medicaid program benefit. Services may be combined on one claim as one stay until the time the mother is discharged.
- ✓ Baby remains in hospital, i.e., baby is not well and becomes a patient in its own right. The baby requires its own State ID number. The baby's charges must be billed separately.

Mother in Hospital - Mother is Not Covered by Medicaid

- ✓ Baby is to be covered by Medicaid and becomes a patient in its own right. Baby requires its own State ID number. Baby's charges are billed separately.

Special Instructions for Labor and Delivery Claims

If a sterilization is performed in conjunction with delivery without the proper consent form (MED-178), the coding and charges for sterilization must be omitted from the claim. Only the codes and charges for the delivery can be billed.

Sterilization is not a covered benefit for undocumented aliens. If sterilization is performed in conjunction with the delivery for an undocumented alien, only the codes and charges for the delivery can be billed.

Interim payments

The Colorado Medicaid Diagnosis Related Groups (DRG) payment system requires that claims for inpatient stays in Prospective Payment System (PPS) hospitals be submitted after discharge. When long-term stays (e.g. neonates, catastrophic illnesses, and trauma patients) in PPS hospitals create large account receivables, PPS hospitals may bill interim claims.

Criteria:

Providers must meet the following criteria to receive an interim payment:

1. Medicaid must be the primary payer. Interim payments cannot be made when the client has other medical resources such as Medicare or commercial health insurance coverage.
2. The *Medicaid payable amount* (not the billed charges) must be at least $100,000 when the interim claim is billed.
3. After the first interim payment, additional requests may be submitted **only** *when the additional Medicaid payment amount reaches or exceeds $100,000.*

Procedures:

1. Submit all interim claims directly to the fiscal agent.
2. Bill the first interim claim (Type of Bill 112 – First Interim Claim) for the services performed from the admission date through the billing date. Bill Patient Status 30 with Type of Bill 112.
3. Bill additional interim claims (Type of Bill 113 - Continuous Interim Claim) only when the total Medicaid payment is at least $100,000 more than the previous interim payment. Bill Patient Status 30 with Type of Bill 113. Continuous Interim Claims must cover the entire hospital stay from the admission date through the billing date.*
4. Bill the final interim claim (Type of Bill 114 – Last Interim Claim) after the client has been discharged. Bill Patient Status 01 with Type of Bill 114. The final claim should cover the entire hospital stay from the admission date through the discharge date.

* Continuous Interim Claims and Last Interim Claims result in a credit of any prior interim claims that have been paid.

Billing procedures for Medicare Part B only coverage

Providers should submit a claim to Medicare for any inpatient services covered by Medicare. When Medicaid denies automatic crossovers for Part B services, submit an inpatient claim to Medicaid. This is *not* a crossover claim.

- Complete the Type of Bill field using 11*X*.
- Enter Payer source code H for the Medicare Part B payer.
- Enter the Medicare Part B payment in the Prior Payments field for Payer source H.
- Deduct the Medicare Part B payment from the total charges to show the Estimated Amount Due.

Medicaid pays the Medicaid inpatient allowable amount minus the Medicare Part B payment, minus any commercial insurance payment (if applicable) and minus any Medicaid copayment. An example of a Medicare Part B only claim is included with this bulletin.

Please direct questions about Medicaid billing or the information in this bulletin to:
Medicaid Provider Services
303-534-0146 or 1-800-237-0757 (toll free Colorado)

Quick Reference

for completing Medicare Part B only claims
(*Note*: This is *not* a Medicare Crossover Claim)