Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

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Provider enrollment, Provider information, Changes, Signature authorization, and Claim requisitions
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Medicaid Fiscal Agent Information on the Internet

coloradomedicaid.acs-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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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: Nursing Facility providers **March 2002**

Reference: B0200127

Billing policy and clarification

Medicare crossover claims

Effective April 01, 2002, Medicaid will process carrier submitted electronic claims. This is a change to the current policy that requires providers to resubmit these claims on the UB92 claim form. Beginning April 1, 2002, the electronic crossover claims will pay in the Medicaid processing system as Part B crossovers.

Supply revenue codes

Providers will no longer be able to bill the supply revenue codes (27X) on the UB92 Medicare crossover claims. This will be effective July 1, 2002.

The following information clarifies the use of occurrence code 42 for Nursing Facilities billing the Medicaid program.

When to use occurrence code 42

1. The client is transferred to another facility,
2. The client is discharged to home, or
3. The client is discharged due to death.

When providers use occurrence code 42, the Medicaid processing system automatically closes the Nursing Facility (NF) Prior Authorization Request (PAR) on the date associated with occurrence code.

Reminder

Use value code Y1 (medical leave days) to show the number of days the client is in the hospital before returning to the NF.

Billing for clients with Medicare

When a client in a nursing facility has a hospital stay and returns to the nursing facility, if the claim meets certain Medicare Part A criteria (e.g., over 72 hours inpatient), then the client is covered by Medicare Part A for up to 100 days after returning to the NF. The example below shows how to bill for a client in this situation.

Example:

<table>
<tr><td colspan="3">Client is covered by Medicare Part A from April 3 through July 12</td></tr>
<tr><td colspan="2">Inpatient hospital
March 28 through April 2</td><td rowspan="2">Discharged from hospital Return to Nursing Facility</td></tr>
<tr><td>March 28 – March 31</td><td>April 1 – April 2</td></tr>
<tr><td>Submit Medicaid claim for this period and the prior period when the client was in the NF. Use value code Y1 to show the number of days (4) that the client was in the hospital.</td><td colspan="2">No Medicaid claim submission is necessary until July 13</td></tr>
<tr><td colspan="3">The PAR remains open when the provider uses value code Y1 and does not enter occurrence code 42 on the claim.</td></tr>
</table>

Nursing Facility Specialty Manual replacement page

Please replace the following pages:

Replace:	With:
Page 11, revision date 11/99	Page 11, revision date 02/02
Page 12, revision date 11/99	Page 12, revision date 11/99

Please read the attached revision carefully, update the specialty manual and discard obsolete or outdated information.

Each Medicaid-enrolled provider receives a single copy of the provider manual. Copy the manual, manual updates, and bulletins as needed. Providers are responsible for making updated billing information available to billing personnel and billing services.

Please direct questions about Medicaid billing or the information in this bulletin to Medicaid Provider Services at:

303-534-0146 or
1-800-237-0757 (toll free Colorado).

FIELD LABEL	Special Instructions
32.- OCCURRENCE CODE AND DATE **35.**	Conditional Complete both the code and date of occurrence when applicable. 42 – Client is transferred to another facility, Client is discharged to home, or Client is discharged due to death. Use one of the following for Medicare crossover claims: 50 - Medicare Pay Date 51 - Medicare Denial Date 53 - Late Bill Override Date See the main UB-92 provider manual for additional codes that may apply.
36. OCCURRENCE SPAN CODE/ **FROM AND THROUGH DATES**	Conditional Complete if nursing facility bills PETI revenue code(s) on the claim. Enter occurrence span code 80 for PETI services. Enter the "FROM and THROUGH" dates for the PETI services in MM/DD/YY format. The occurrence span must encompass the dates for all PETI services submitted on this claim. Use the *earliest* "FR" date and the *latest* "THROUGH" date approved on the PETI PAR(s).
39.- VALUE CODES AND AMOUNT **41.**	Conditional Complete when there is an applicable value code. If a value code is entered, a dollar amount or related numeric value must be entered. <u>Days</u> Y1 - Medical Leave Days - See explanation in the Special benefits/limitations/exclusions section. Y2 - Non-Medical Leave Days - See explanation in the Special benefits/limitations/exclusions section. Y3 - Programmatic Leave Days - See explanation in the Special benefits/limitations/exclusions section. <u>TPL</u> A1 - Deductible Payer A \ B1 - Deductible Payer B } The amount applied to the patient's C1 - Deductible Payer C / deductible for the indicated payer A2 - Co-Insurance Payer A \ The amount applied to the B2 - Co-Insurance Payer B } patient's coinsurance C2 - Co-Insurance Payer C / for the indicated payer A3 - Estimated Responsibility Payer A \ B3 - Estimated Responsibility Payer B } The amount paid by C3 - Estimated Responsibility Payer C / the indicated payer
42. REV CD (REVENUE CODE)	Required Use only the revenue codes listed in this supplement for nursing facility claims. For Medicare part A crossover claims use: 119 - Private 129 – Semi-private For Medicare part B crossover claims use: 169 – Medicare B, Ancillary services

Field Label	Special Instructions
42. Rev Cd (Revenue Code) CONTINUED	For PETI charges use: 259 – Non-covered prescription drugs 479 – Hearing and ear care 962 – Vision and eye care 969 – Dental services 982 – Chiropractic services 999 – Health insurance premiums and other services
43. Description	Required
44. HCPCS/Rates	Required Enter the rates (dollar amounts) for accommodations
46. Serv Units (Units of Service)	Required Enter the number of covered days.
47. Total Charges	Required Enter the total charge for each revenue code. For each PETI revenue code, enter the amount paid in the month entered in "STATEMENT COVERS PERIOD", FL 6. For Medicare part B claims, enter the total ancillary charges billed to Medicare. Enter the total for all lines on the line with revenue code 001.
50. Payer (Payer Identification)	Required Enter the payment source code followed by the name of each payer organization from which the provider might expect payment. At least one line must indicate Medicaid. <u>Source payment codes</u> B - Workmen's Compensation C - Medicare D - Medicaid E - Other Federal Program F - Insurance Company G - Blue Cross including Federal Employee Program H - Other - Inpatient (Part B Only) I - Other Line A - Primary Payer Line B - Secondary Payer Line C - Tertiary Payer
51. Provider No. (Billing Provider Number)	Required Enter the nursing facility's eight-digit Medicaid provider number.
54. Prior Payments/Payers and/or Patient Payment	Conditional Enter third party and/or Medicare payments. **List patient payment on the 4th line. This is a separate entry from other third party payers.** **If there are PETI charges on the claim, this amount must be greater than the *total* amount billed for PETI charges.**
55. Est Amount Due (Estimated Amount Due)	Conditional Complete when there are Medicare/third party payments.