

MDCH Institutional Billing Resource

Billing Issue ¹	Applicable Provider Types	Action
OI-Service not covered	Inpatient, Outpatient, LTC, Home Health, Hospice	Occurrence code 24 and date
OI Coverage terminated, benefits exhausted, or invalid insurance code on Medicaid Eligibility Card	Inpatient, Outpatient, LTC, Home Health, Hospice	Occurrence code 25 and date
Reporting amount applied to co-insurance, co-pay, or deductible, (OI & Medicare).	LTC, Home Health, Hospice	Value Code A1, B1, C1, A2, B2, C2, A7, B7, C7 and amount.
Reporting amount applied to co-insurance, co pay or deductible (OI & Medicare).	Inpatient, Outpatient,	<p>DOS prior to 7-01-2007: paper/electronic claims: Value Code A1, B1, C1, A2, B2, C2, A7, B7, C7 and amount.</p> <p>DOS on/after 7-01-2007: <u>Electronic claims:</u> Use CAS segments Only <u>Paper Claims:</u> Use Value Codes Only</p>
Reporting Contractual Adjustments. Providers who work with billing agents are responsible for ensuring the contractual adjustment amounts are reported correctly on both paper and electronic claims.	Inpatient, LTC, Home Health, Hospice, Outpatient	<p>Electronic Billing: Report contractual adjustment amount using the appropriate adjustment reason code. Do not combine with the payment amount.</p> <p>Paper Billing: Contractual adjustment is added to the primary payer's payment and reported in Prior Payments.</p>
Medicare Part A	Inpatient effective during stay	Occurrence code A2 and date Medicare A became effective. Non-covered days must be reflected.
	Inpatient exhausted during or prior to stay	Occurrence code A3 and date Medicare A exhausted. Non-covered days must be reflected.
Private Room	Inpatient	Use condition code 38 (semi-private room not available) or 39 (private room medically necessary).
Readmission and Re-hospitalization within 15 days or less	Inpatient Unrelated condition, same or different hospital.	Use occurrence span code 71 and indicate the prior stay from and through dates. First stay <u>must be submitted</u> and <u>paid</u> prior to submission of the second stay.
	Inpatient related condition, same hospital.	Combine the stays onto one claim. Use occurrence span code 74 and indicate the From and Through dates of the days between the admissions. Also report revenue code 180 with the claim line quantity showing the days between the admissions.
Therapeutic/LOA leave days	Inpatient, LTC	Report occurrence span code 74 with the From and Through dates of the leave. Use revenue code 180 (IPH) or 183 (LTC) & claim line must show quantity of the leave days.
Hospital Leave Days	LTC	Report occurrence span code 74 with the From and Through dates of the leave. Use revenue code 185 and claim line must show quantity of the leave days.

¹ See Medicaid Provider Reference Manual - Billing and Reimbursement for Institutional Providers Chapter. (Sections noted in parentheses.)

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Two Facilities In One Month	LTC, Inpatient	First facility must report Patient Status Code 03 - DC/transfer to SNF
		Second facility must report Source of Admission 05 - transfer from SNF
Attach Documentation	Inpatient, Outpatient, LTC, Home Health, Hospice	Indicate "Documentation attached" in remarks. Brief description is desired (e.g. "Medical Doc/OI EOB/RA's Attached").
Individual Consideration	Outpatient Multiple visits on Same Day	Use condition code G0 (zero) when billing for multiple visits on same day, same revenue center, and visits distinct & constituted independent visits. Include in remarks section reason/time of each visit.
	Outpatient All other IC requests	For all other requests for IC use modifier 22 only once on the claim. Must include documentation/justification for additional payment requests.
Multiple page paper claims.	Inpatient, LTC, Home Health, Hospice	<p>Please correctly complete line 23 (paper only) of the UB 04. Please bill electronically to avoid delays.</p> <p>Inpatient hospitals can report charges on multiple pages when services exceed more than 22 lines. MDCH is unable to accept multiple-page paper claims for all institutional providers. Providers are encouraged to bill electronically whenever possible for faster payment.</p>
Patient Spend-down	Outpatient, Home Health	Value code 66 and amount
Patient Pay	Inpatient, LTC, Hospice	Value code D3 and amount
Off-Set to Patient-Pay	LTC, Hospice	Report the appropriate Off-Set value code and amount. Also report value code D3 & amt. (Patient Pay minus the off-set amount).
Outpatient Prospective Payment System (OPPS)	Packaging & APC Payments	<p>Providers must report all HCPCS/services and all charges for all services on the same claim, whether payment for the services is paid or is a packaged (status indicator [S/ 'N']).</p> <p>Charges related to the packaged services are used for outlier payments and/or future rate setting. Do not leave packaged/bundled (status indicator 'N') services off your claim and report all services (on the same claim) for your OPPS/APC claim to pay correctly.</p>

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