UB-04 Claim Billing Reimbursement

HP Provider Relations/2014 IHCP Annual Seminar
Agenda

• Objectives
• Institutional Claim Basics
• Inpatient Claim Payment
• Outpatient Claim Payment
• Billing Specifics
• Denial Avoidance and Resolution
• Find Help
• Questions
Objectives

- Understand claim payment basics
- Learn how inpatient and outpatient claim pricing is determined
- Discover how to avoid and research claim denials
Institutional Claim Basics
Types of Institutional Claims

• 837I – Electronic transaction
  - Companion guide available on IHCP Companion Guides web page at indianamedicaid.com

• Web interChange

• Paper claim

• Adjustment request (for a previously paid claim)
Providers Using the Institutional Claim Format

IHCP Provider Manual, Chapter 8, Section 2

- Ambulatory surgical centers (ASCs)
- Birthing centers
- End-stage renal disease (ESRD) clinics
- Home health agencies (HHAs)
- Hospice providers
- Hospitals
- Long-term care (LTC) facilities
- Rehabilitation hospital facilities
Inpatient Claim Payment
Inpatient Hospital Services

Define

- Inpatient services are covered when the services are provided or prescribed by a physician, AND when the services are medically necessary for the diagnosis or treatment of the member’s condition.
- Services other than emergency admissions, vaginal deliveries, C-section deliveries, and newborn stays require a prior authorization (PA).
- Members dually eligible for Medicare and Medicaid must obtain PA for an inpatient stay that is not covered by Medicare.
Inpatient Hospital Services
Revenue Code Itemization

• Although the IHCP reimburses inpatient hospital services using a diagnosis-related group (DRG)/Level of Care (LOC) methodology, the IHCP requires a complete itemization of services performed using appropriate revenue codes in field 42

• The revenue code reveals crucial information about the type of service provided during the inpatient stay

• The revenue code that is used must reflect the setting in which the care was delivered
  - For example, providers must use revenue code 20X to submit a claim for services provided to patients admitted to an Intensive Care Unit
Inpatient Hospital Services

Critical components of a DRG inpatient reimbursement system

- Grouper Version AP DRG 18.0
- Relative Weight
- DRG Base Rate
- Length of Stay (LOS)
- Outlier
Inpatient Hospital Services
DRG calculation components
Outpatient Claim Payment
Outpatient Hospital Claims

• Outpatient hospital services are those provided to members who are not registered as inpatients at a hospital
• Outpatient services are covered when they are provided or prescribed by a physician and when the services are medically necessary for the diagnosis and treatment of the member’s condition
• Four categories of service within the outpatient hospital prospective payment system:
  – Outpatient surgeries
  – Treatment room visits
  – Stand-alone services
  – Add-on services
Outpatient Hospital Claims

Outpatient surgeries

• Outpatient surgeries are reimbursed at an all-inclusive flat rate (ASC rate) that covers all related procedures
  – The IHCP does not allow stand-alone services with any surgical revenue code

• Surgical revenue codes
  – 36X Operating room services
  – 49X Ambulatory surgical care

• Each procedure code linked to a surgical revenue code is assigned one of 16 ASC indicators
  – ASC rates are available on the IHCP Fee Schedule

• A maximum of two procedures will be reimbursed
  – The highest ASC rate pays 100%
  – The second highest ASC rate pays 50%
# Outpatient Surgery

## Payment example with ASC procedure code

The IHCP reimburses an all-inclusive flat fee that includes all related procedures for outpatient surgeries provided in either a hospital or an ambulatory surgical center (ASC), emergency department or clinic.

### Example Table

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**Note:** EOB 4095 – Non-surgical services are not reimbursed
Outpatient Claims

Treatment rooms

• Treatment room revenue codes are reimbursed via the ASC methodology when billed with an appropriate surgical procedure code (10000-69999)
  - 45X Emergency department
  - 51X Clinic
  - 52X Freestanding clinic
  - 70X Cast room
  - 71X Recovery room
  - 72X Labor/delivery room
  - 76X Treatment/observation room

• If a non-surgical procedure is performed, submit a treatment room revenue code without listing a procedure code
  • Reimbursement will be at a statewide "flat" rate for each revenue code
Outpatient Claims

Stand-alone services

- Stand-alone services include therapies, diagnostic testing, laboratory, and radiology
- Stand-alone services can be billed separately or in conjunction with treatment rooms
- Stand-alone services are reimbursed at a statewide flat rate by revenue code
  - Exception: Laboratory and radiology reimbursed at procedure code fee schedule amount
- *IHCP Provider Manual, Chapter 8, Stand-alone Services Table* gives a complete list of stand-alone revenue codes
Outpatient Claims

Add-on services

• Add-on services include drugs, IV solutions, medical supplies, blood, and oxygen
• When billed with stand-alone procedures, add-on services are separately reimbursable at a statewide flat rate by revenue code
• If billed with a treatment room revenue code, some add-on services are separately reimbursable at a statewide flat rate by revenue code
  – 255 Drugs incident to radiology
  – 258 IV Solutions
  – 29X DME
  – 38X Blood storage and processing (excluding 380, 381, 382, 385, and 389)
  – 39X Blood & Blood Component Admin, Processing & Storage
Outpatient Surgery
Payment example with no ASC procedure code

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Note: EOB 9063 – Service is priced by flat rate on file.

Add-on and Stand alone services paid with non-surgical claim.

Treatment Rooms without Surgical Procedure codes are paid at the flat rate on file.
Revenue Code 451

Emergency room services

• The IHCP will reimburse for a screening service when emergency room services are provided to a member whose diagnosis does not constitute an emergency
• Providers report revenue code 451 when billing for the screening service
• Payment is denied for all ancillary services reported on the same date of service as revenue code 451
Billing Specifics
Inpatient Stays Less than 24 Hours

• Inpatient stays less than 24 hours should be billed as an outpatient service
  – Exceptions:
    ➢ DRG 637 Neonate, died within one day of birth, born here
    ➢ DRG 638 Neonate, died within one day of birth, not born here
• Inpatient claims for stays less than 24 hours will deny for edit 0501 – *Discharge within 24 hours of inpatient admission*
Outpatient Services within Three Days of an Inpatient Stay

• Outpatient services that occur within three days preceding an inpatient admission to the same facility, for the same or related diagnosis, are considered part of the corresponding inpatient admission

• “Same” or “related” refers to the principal diagnosis and is based on the first three digits of the ICD code
Inpatient Services

Readmissions

• A readmission is defined as a hospital admission within three days following a previous hospital admission and discharge, from the same hospital, for the same or related condition

• “Same” or “related” is based on the principal diagnosis, and is based on the first three digits of the ICD code

• Providers should bill one inpatient claim when the patient is readmitted within three days of a previous inpatient discharge
Inpatient Claims

Readmission – Billing example

- Patient is admitted September 19, 2014, and discharged September 23, 2014
- Patient is readmitted September 25, 2014, and discharged September 28, 2014
- The hospital bills with STATEMENT COVERS PERIOD FROM 9/19/14 THROUGH 9/28/14
- Covered days are nine
  - September 19-27, 2014
- Room and board days are seven
  - September 19, 20, 21, 22, 25, 26, and 27
Inpatient Claims

Transfers

• Receiving hospital is reimbursed on DRG or LOC methodology
• Transferring hospital is reimbursed a DRG prorated daily rate for each day
  – Daily rate is DRG rate divided by ALOS (average length of stay)
• The appropriate discharge status must be placed in field 17
• Transferring hospitals do not receive separate DRG reimbursement when the patient returns from the transferee hospital for the same condition
  – Original admission and subsequent return must be combined on one claim
• DRGs 639 and 640 (Neonates transferred < 5 days old) exempt from the transfer policy
• Claims for patients transferred within 24 hours of admission are billed as outpatient
Inpatient Admissions

Prior authorization

- PA is required for most urgent and nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions
  - Applies to medical and surgical inpatient admissions
- Emergency admissions, trauma, vaginal deliveries, C-section deliveries, and newborn stays do not require PA
- Observation does not require PA – billed as an outpatient service
- Inpatient admissions for burn care do not require PA, if admit type is 01 (emergency) or 05 (trauma)
  - Applies to Traditional Medicaid, including Care Select
  - Applies to the dually eligible if Medicare does not cover the stay
Outpatient Mental Health Hospital Services

• As required by 405 IAC 5-20, Covered Services, providers cannot use revenue codes 500, 510, 90X, 91X, and 96X to bill covered outpatient mental health hospital services
• Covered outpatient mental health codes can only be billed with revenue code 513
• Providers are required to bill for individual, group, or family counseling procedure codes listed in Chapter 8, Section 2, of the IHCP Provider Manual using revenue code 513 – Clinic/Psychiatric
Stand-alone Chemotherapy

- Chemotherapy services consist of four components:
  - Administration of chemotherapy agent
  - Chemotherapy agent
  - Intravenous (IV) solution and equipment
  - Treatment room services

- Each of the four components is separately reimbursable when chemotherapy is administered using the following code combinations:
  - Administration of chemotherapy agent – Revenue codes 331, 332, or 335; codes 96401 through 96549
  - Chemotherapy agent – Revenue code 636 – Drugs requiring detailed coding, along with the appropriate HCPCS code
  - IV solution and equipment – Revenue code 258 for the IV solution and revenue code 261 for IV equipment
  - Treatment room services – Bill using revenue codes 45X, 483, 51X, 52X, or 76X
Stand-alone Radiation

- Radiation treatment services consist of two components:
  - Administration of radiation treatment
  - Treatment room services
- Both components are separately reimbursable, using the following code combinations:
  - Administration of radiation treatment – Revenue codes 330, 333, or 339; CPT radiation treatment codes 77261 through 77799
  - Treatment room services – Revenue codes 45X, 483, 51X, 52X, or 76X

Note: When chemotherapy and radiation treatment services are rendered on the same day, bill all applicable components to the IHCP
End-Stage Renal Disease (ESRD)

• Patients who have ESRD, a chronic condition with kidney impairment considered irreversible and permanent, require a regular course of dialysis or a kidney transplant to maintain life

• Hemodialysis or peritoneal dialysis is reimbursed at a daily composite rate, which covers the cost of the dialysis session, including the durable and disposable items and medical supplies

• Nonroutine lab work and drugs may be billed separately, see Chapter 8 of the Indiana Health Coverage Programs Provider Manual for more information.

• Services may be provided in an outpatient hospital setting, an ESRD clinic, or in the patient’s home
End-Stage Renal Disease (ESRD)

• Each date-specific service must be billed on a separate line
• Type of bill codes (TOB)
  - Freestanding renal dialysis facilities – TOB 721
  - Outpatient hospital renal dialysis facilities – TOB 131
  - Inpatient renal dialysis services – TOB 111
• Revenue Codes
  - 82X – Hemodialysis composite rate
  - 83X – Peritoneal dialysis composite rate
  - 84X – CAPD (continuous ambulatory peritoneal dialysis)/composite rate
  - 85X – CCPD (continuous cycling peritoneal dialysis)/composite rate
  - 634/635 – Epoetin (with appropriate HCPCS code)
  - 636 – Drugs (with the appropriate HCPCS code)
  - 30X – Nonroutine lab (with the appropriate HCPCS code)
Denial Avoidance and Resolution
520 – Invalid Revenue Code/Procedure Code Combination

• Claims denied with revenue code/procedure code link (Edit 520)
  - Consult UB editor for correct linkage
  - Call HP Customer Service to see if the revenue code and procedure code is linked
  - Request consideration to link revenue code and procedure code

  ➢ *Policy Consideration Form* on the [Forms](#) page at indianamedicaid.com
2058 – Invalid Family Planning Diagnosis/Procedure Code

- **IHCP Provider Manual, Chapter 8, Section 4, at indianamedicaid.com**
- **Bulletins and banner pages at indianamedicaid.com**
  - Sign up for **automated email notifications** at indianamedicaid.com for notification of changes and updates
3014 – Substance abuse and acute inpatient stays require PA (BT201060)

- Review Prior Authorization Inquiry screen on the Web interChange
  - Dates of service
  - Code billed
- Claim editing is based on the “admission type” indicated on the Institutional claim
- PA is required for inpatient admissions excluding:
  - Emergency
  - Routine vaginal deliveries
  - C-section deliveries
  - Newborn stays
6515 – Inpatient service performed three days after outpatient services
6516 – Outpatient services rendered within three days prior to admit date of paid inpatient claim

- Research member claim history in Web interChange
- If no claim found:
  - Call HP Customer Service to research claim history that is causing denial
- Void claim that is paid in history causing denial
- Resubmit inpatient claim no sooner than the next day
Find Help
Helpful Tools

• IHCP website at indianamedicaid.com
• Provider Enrollment
  – 1-877-707-5750
• Customer Assistance
  – 1-800-577-1278
• Provider Relations Field Consultants at indianamedicaid.com
• Written Correspondence
  – P.O. Box 7263
    Indianapolis, IN 46207-7263
Questions