Inpatient and Outpatient Services Billing

Presented by
EDS Provider Field Consultants
Agenda

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- NPI
- New Paper Claim Form
- Who bills on a UB-04 Claim Form?
- Inpatient Claims
- Reimbursement Methodology
- Outpatient Services
- Sterilization Procedure
- General Information
- PET Scans
- NDC Billing
- Long-Term Acute Care
- Home Health Services
- Hospice Services
- Crossover Claims
- Medicare Replacement/HMO Policies
- Medicare Exhausts
- Top Five Denials
- Helpful Tools
- Questions
Objectives

At the end of this session, providers will understand:

- Billing requirements for:
  - Stays less than 24 hours
  - Readmissions and Transfers
  - 72-Hour Observation

- Billing guidelines for home health and hospice services

- Billing guidelines for long-term care

- How to bill crossover claims

- How to avoid the top reasons for claim denials for UB billers
NPI - Reporting

Compliance date: To be determined

• The following functions will not be able to be performed if the NPI is not obtained and reported to the Indiana Health Coverage Programs (IHCP):
  – Eligibility inquiry
  – Claim submission
  – Claim inquiry
  – Check inquiry
  – Prior authorization submission and inquiry

• Access the NPI application online at: https://nppes.cms.hhs.gov/NPPES/Welcome.do
Hospital Subparts

- OMPP and EDS are finalizing enrollment forms
- Choices available for types of subparts will be listed on the form
- Subparts will reflect the existing 9 digit provider number followed by a distinct alpha character
- Monitor future newsletters and the IHCP web site for additional information
NPI Edits

• 1100-1129
  - These edits will cause full claim denial if not resolved upon NPI Phase III
UB-04 Paper Claim Form

FL1: Billing provider information (must include ZIP Code +4)

FL56: Billing provider NPI

FL57: Billing provider LPI

FL81CC a: Qualifier B3 and billing provider taxonomy for Field 56
FL81CC b: Qualifier B3 and attending provider taxonomy for Field 76.

FL76-77: NPI or qualifier 0B and license number
## Current Statistics for UB-04 Claims

### Stats for August 2007

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<tr>
<th></th>
<th>UB-92</th>
<th>UB-04</th>
<th>Total</th>
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<tbody>
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<td>2,470</td>
<td>9,361</td>
<td>11,831</td>
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79.12% of all paper claims received are on new UB-04 forms!
Who Bills on a UB-04 Claim Form?

- Ambulatory Surgery Centers (ASC)
- End-Stage Renal Disease (ESRD) Clinics
- Home Health Agencies (HHA)
- Hospice Providers
- Hospitals
- Long-Term Care (LTC) Facilities
- Rehabilitation Hospital Facilities
Inpatient Claims
Covered Services

• Inpatient services, such as acute care, mental health, and rehabilitation care are covered when the services are provided or prescribed by a physician and are medically necessary for the diagnosis and treatment of the member’s condition.
Inpatient Claims
General Information

• Providers must verify member eligibility to determine if the patient is enrolled in risk-based managed care (RBMC) or Traditional Medicaid. The provider must bill the appropriate payer.
Inpatient Claims
Less than 24-Hour Stays

• For less than 24-hour stays, hospitals will be paid under the outpatient reimbursement methodology.

• Trauma cases less than 24 hours are treated as outpatient claims.

• The time starts when the doctor writes the order to admit the patient.

• Inpatient stays less than 24 hours that are billed as inpatient claims will be denied or will be subject to retrospective review.
Inpatient Claims
Less than 24-Hour Stays

• Claims submitted as inpatient claims with the same from and through date will deny for edit 0501 – *Discharge within 24 hours of Inpatient admission*.

• Claims submitted for inpatient stays with the through date of service one day later than the from date of service will be subject to post payment review.
  - These claims should be billed as outpatient claims.
  - Example: Dates of service October 19, 2006, to October 20, 2006
Inpatient Claims

Less than 24-Hour Stays

• Claims grouping to diagnosis-related grouping (DRG) 637 – *Neonate, died within one day of birth, born here*, or DRG 638 – *Neonate, died within one day of birth, not born here*, are exempt from this policy.
Inpatient Claims
Less than 24-Hour Stays

• For the 24-hour rule, claims for patients that are transferred within 24 hours of admission are to be billed as outpatient claims except for the previously mentioned neonate DRGs.

• If a patient is admitted as acute care and moved to a psychiatric wing, then returns to acute care, the provider should submit two claims. Submit one claim for the acute care stay and another for the psychiatric stay.

• Critical access hospitals (CAH) are treated the same as all other acute care hospitals.
Inpatient Claims
Mental Health

- A psychiatric hospital must meet the following conditions to be reimbursed for inpatient mental health services:
  - Must enroll in the IHCP
  - Must maintain special medical records for psychiatric hospitals required by 42 CFR 482.61
  - Must provide service under the direction of a licensed physician
  - Must meet federal certification standards for psychiatric hospitals
  - Must meet utilization review requirements

- PA is required for all inpatient psychiatric admissions, including admissions for substance abuse
Inpatient Claims
Hospital Readmissions

• Readmissions for same or related diagnosis to the same hospital within three calendar days after discharge are treated as the same admission for payment purposes. If billed separately, the second claim will deny
  – 6518 - *Inpatient claim admit date is three days after the discharge date of another paid inpatient claim.*

• If the second claim is submitted and paid before the first claim, the first claim will deny
  – 6517 - *Inpatient discharge claim is three days before the admission date of another paid inpatient claim.*

• Effective November 1, 2004, the second inpatient claim costs are added to the first inpatient claim when determining the diagnosis-related grouping (DRG) weights.
Inpatient Claims
Hospital Readmissions

• The same hospital is defined as same provider number.

• The provider number is not differentiated by the alpha character after number.
  – Example: Provider number 300456789A is considered the same hospital as provider number 300456789B.

• The same or related diagnosis refers to the primary or principal diagnosis code and is based on the first three digits of the ICD-9-CM code.
Inpatient Claims
Hospital Readmissions

Example:

• A member is admitted October 19, 2006, and is discharged October 23, 2006. The member is readmitted October 25, 2006, and is discharged October 28, 2006.

• The hospital bills from DOS October 19, 2006, through DOS October 28, 2006. The number of covered days is nine. The number of room and board days is seven.
Inpatient Claims
Hospital Transfers

• The IHCP no longer reimburses a separate DRG for members that return from a transferee hospital.

• When determining DRG weights effective November 1, 2004, subsequent transfer claim costs were added to the first inpatient claim.

Please reference IHCP provider bulletin BT200420 dated September 19, 2004, for more information.
Inpatient Claims
Hospital Transfers

**Example 1:**

- A member is admitted to Hospital A, transfers to Hospital B, then transfers back to Hospital A.
- Hospital A must include the original admission and the return stay charges on one claim. Transfer claims are subject to retrospective review.
Inpatient Claims
Hospital Transfers

Example 2:

• A member is admitted to Hospital A on October 19, 2006, and is transferred to Hospital B on October 25, 2006. The member transfers back to Hospital A on November 1, 2006, and is discharged on November 9, 2006.

• Hospital A bills dates of service October 19, 2006, to November 9, 2006. The number of covered days is 21. The number of room and board days is 14 days. Hospital A bills a discharge status code.

• Hospital B bills dates of service October 25, 2006, to November 1, 2006. The number of covered days is seven and the number of room and board days is seven. Hospital B bills a transfer status code.
Inpatient Claims
Hospital Transfers

Exceptions:

• Claims grouping to DRGs 639 – Neonate, transferred < 5 days old, born here, and 640 – Neonate, transferred < 5 days old, not born here, are exempt from this transfer policy.

• Additional costs incurred as a result of a patient’s return from a receiving hospital are eligible for cost outlier reimbursement.
Reimbursement Methodology
Outpatient

• For all covered hospital services and ambulatory surgical center (ASC) services, reimbursement is the lower of the submitted charge or the Medicaid allowed amount.

• Outpatient surgical procedures are reimbursed using the ASC methodology. Each procedure code is assigned an ASC rate value.

• There are 15 ASC payment groups.
Reimbursement Methodology
Diagnostic Related Groupings

• The IHCP continues to use the All-Patient (AP) DRG Grouper, version 18.

• No changes have been made to the DRG base rate
  – $2,812.50 for acute care services
  – $3,375.00 for eligible children’s hospitals

DRG relative weights and average length of stays are periodically changed to reflect relative cost and treatment patterns.
Reimbursement Methodology

Outliers

- The threshold for determining outliers is $34,425 or two times the DRG, whichever is higher.
- In August 2005, Myers and Stauffer, LC, notified hospitals of their new global cost-to-charge ratio, which is used to help calculate outlier payments.
Reimbursement Methodology
Cost-to-Charge Ratio

• Low-volume providers, out-of-state providers, and those that did not receive notification of a provider specific rate receive the statewide median cost-to-charge ratio of 0.5015
Reimbursement Methodology
405 IAC 1-10.5.3

• Inpatient hospital Level of care (LOC) payments include psychiatric cases, rehabilitation cases, certain burn cases, and long-term acute care hospitals (LTAC) cases.
• Level of care reimbursement is based on a per diem.
Outpatient Services

• The outpatient hospital prospective payment system is used for four categories of service:
  – Outpatient surgeries
  – Treatment room visits
  – Stand-alone services
  – Add-on services

• If a member is enrolled in RBMC, providers must bill these claims to the appropriate MCO.

• The coverage policies, reimbursement policies, and billing requirements developed by the IHCP are not intended to mirror Medicare.
Outpatient Services
Outpatient Surgery

• When performed in a hospital or ASC, outpatient surgeries are reimbursed on an all inclusive flat fee that includes all related procedures.

• Example:
  – A member arrives at an emergency room, undergoes multiple tests, and has a wound sutured. The IHCP pays the ASC for the surgical procedure. Providers may not drop the surgical procedure code to maximize reimbursement.

• Typically surgeries are provided in an operating room (360 rev code) or an ambulatory surgical center (490 rev code). These revenue codes must always be billed with the surgical CPT code. Procedures can also be provided in emergency room and clinic settings.
Outpatient Services
Treatment Room Revenue Codes

• If no surgical procedure is performed, bill only the treatment room revenue code and the services will be reimbursed at the treatment room rate.

• When billing a surgical Healthcare Common Procedure Coding (HCPCS) code, use one of the following treatment room revenue codes:
  
  45X  70X  72X
  51X  71X  76X

• Surgical revenue codes are 360 and 490.

• According to NL200503, the following are listed as non-covered:
  
  920  942  946
  929  944  947
  940  945  949
  941
Outpatient Services
Services Performed on the Same Day as Surgery

• All outpatient services provided on the same day of the surgery must be included on a single claim.

• Add-on or stand-alone services are not separately reimbursable and are denied.
Sterilization Procedure
Essure

- Billing guidelines effective for dates of service 1-1-05
- Can be performed as an outpatient, in an ambulatory surgical center (ASC) or in a physician office
- Bill procedure code 58565 on UB-04
- Use primary diagnosis code V25.2- Sterilization
- Submit a valid, signed Sterilization Consent form.
- Print “Essure Sterilization” on the claim form or on the accompanying invoice.
- Bill device code A9900 separately on CMS-1500 form under a durable medical equipment (DME) provider number
  - Submit cost invoice with claim

Banner BR200734 contains additional information
General Information
Three-Day Rule

- Outpatient services that occur within three days of an inpatient stay to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission.
- Effective November 1, 2004, outpatient costs are to be added to the related inpatient claim to determine the DRG weight and claim payment amount.

Please refer to IHCP provider bulletin BT200420 for more information.
General Information
Three-Day Rule

• "Same" and "related" refers to the primary diagnosis code and is based on the first three digits of the ICD-9-CM code.

• If an outpatient claim is submitted and paid before the inpatient claim, the inpatient claim denies for explanation of benefits (EOB) code 6515, which instructs the provider to bill services on the inpatient claim.
  - In this case, the provider must void the outpatient claim and then bill the inpatient claim for both the outpatient and inpatient charges.

• If the inpatient claim pays before the outpatient claim, the outpatient claim denies for EOB code 6516, which instructs the provider to perform a replacement to add the outpatient charges to the inpatient claim.
General Information

Three-Day Rule

Example:

- A member has outpatient surgery on October 19, 2006.
- On October 21, 2006, the member is admitted as an inpatient for the same or related diagnosis to the same hospital.
- The outpatient charges must be combined with the inpatient bill.
- The member is discharged on October 25, 2006.
- The number of covered days is four days.
- Room and board days or units are four.
PET Scans

Per IHCP provider bulletin *BT200516*, published July 22, 2005, PET Scans with a date of service on or after, January 28, 2005, are to be billed on the UB-04 claim form using an appropriate CPT code and ICD-9-CM diagnosis code.
National Drug Code (NDC) Billing

• Federal Deficit Reduction Act 2005 (BT200713)
• NDCs will be required on the UB-04 effective January 1, 2008
• Bulletin will be forthcoming to outline NDC billing instructions
Long-Term Care
Covered Service Standards

• Eligibility requirements
  – Prescreening for Level of Care
  – Must have an approved 4B (county) or 450B (state) on file
Long-Term Care
Bed Hold

• Occupancy must be at 90 percent or greater for reimbursement
• Eligibility for bed-hold reimbursement shall be determined as of the first day of an IHCP resident’s leave of absence
• Billing
  – 180 – Bed-hold days *not eligible for payment*
  – 183 – Therapeutic bed-hold days *eligible for payment (30 per year)*
  – 185 – Hospital bed-hold days *eligible for payment (14 consecutive days)*

See Chapters 8 and 14 of the *IHCP Provider Manual* for more information about long-term care coverage and billing procedures.
LTAC Reimbursement Methodology

405 IAC 1-10.5.3

Long-term acute care hospitals are:

- Freestanding general long-term acute care hospitals (does not mean a wing or specialized unit within a general acute care hospital)
  - Designated by the Medicare program as a long-term hospital; or
  - Have an average inpatient length of stay greater than 25 days

- PA is required for all LTAC admissions

- LTACs are paid a per-diem rate for the days prior authorized

- LTAC must bill under revenue code 101 for an all-inclusive rate
Home Health Services

• Billing units of home health visits for therapists, Home Health Aids (HHA), Licensed Practical Nurses (LPN) and registered nurses (RN) should be rounded as follows:
  – For therapy visits, if in the home 1-7 minutes, units cannot be rounded and are not billable. Services consisting of 8-15 minutes can be billed as one 15 minute unit of service.

• For HHA, LPN, and RN visits, the claim should be billed as follows:
  - If in the home less than 29 minutes, the entire first hour can be billed only when a service was provided.
  - Example: The nurse walks in and has to call 911 right away for the patient.

• If a member refuses service, the provider cannot bill any units of service.
Home Health Services
Rate Changes

- The IHCP notifies providers of rate changes in IHCP provider bulletins.
- Systematically adjusted claims appear on the remittance advice (RA) with an internal control number (ICN) that starts with a 56 (mass adjustments).

*Note: ICNs that begin with 55 are for long-term care retro-rate adjustments.*
Home Health Services

- Bill visits using code 99600
  - LPNs and LVNs use modifier TE
  - RNs use modifier TD
- When PA is granted for 99600 TD, the PA covers both RNs and LPNs services
Prior Authorization

• **Through October 31, 2007**, mail PA requests to:
  
  Health Care Excel Prior Authorization Department
  
  P. O. Box 531520
  
  Indianapolis, IN  46253-1520

• Obtain emergency PA by calling the HCE Prior Authorization Department at (317)347-4511 or (800) 457-4518.

• **On and after 11-1-07**, mail PA requests to:
  
  ADVANTAGE Health Plan-FFS
  
  P.O. Box 40789
  
  Indianapolis, Indiana 46240

• Or call 1-800-269-5720

• For RBMC members, contact the appropriate MCO
Home Health Services
Overhead Rate

• An overhead rate is provided to cover administrative costs and is reimbursed in addition to a staffing reimbursement component.

• Overhead is billed by encounter, which occurs when an RN, LPN, HHA, or therapist:
  – Enters the home
  – Provides service to one or more members
  – Leaves the home

• Overheads must be reported using occurrence codes, and occurrence dates or occurrence spans in Fields 35a-36b on the UB-04 claim form.

• Occurrence codes are also reported in all electronic claim formats.
Home Health Services

If a member is enrolled in RBMC, providers must contact the appropriate MCO to obtain prior authorization and billing information.
Hospice Services

• IHCP members in need of hospice care:
  - Must be eligible for program services
  - Must have a prognosis of six months or less to live
  - Must elect hospice services

• The hospice provider should ensure that Hoosier Healthwise and Medicaid Select/Care Select managed care members disenroll from managed care before the member elects the hospice benefit.
Hospice Services

• Hospice providers should follow the general billing guidelines for completing a UB-04 claim form and use the appropriate revenue codes as listed in the IHCP Hospice Provider Manual.

Crossover Claims
Processing Electronic Claims

• The Coordination of Benefits Contractor (COBC) crosses over HIPAA-compliant claims to the IHCP.
  – The Centers for Medicare and Medicaid Services (CMS) selected Group Health, Inc. (GHI) to be the COBC
• When Medicare denies claims, they cross over to the IHCP with a denied status.
• The IHCP created new edits for these claims. The edits are 0592 and 0593 – *Medicare denied details*.
• The COBC provided the IHCP with a list of Medicare contractors that provide claim adjudication and that cross through their processing system.
Crossover Claims
Submitting Claims that did not cross over

• Allow 60 days for claims to automatically crossover to the IHCP
• Include qualifiers A1, A2, 06 in field 39 on paper claims showing the co-pay and/or deductibles
• Bill via Web interChange
Medicare Replacement/HMO Policies

• Do not include A1, A2 or 06 in Field 39
• Include name of Replacement/HMO Policy in Field 54a of the UB-04
• Write “Medicare Replacement Policy” on the top of the claim form and EOB
• QMB claims must be special batched to override edit 2007
Medicare Exhausts

• Prior to billing Medicaid inpatient claim, bill all ancillary services for dates of service after the Medicare benefits exhausted to Medicare Part B
• Include Part B payment as TPL in field 54
• Void Medicare B crossover claim prior to billing Medicaid inpatient claim
• Attach proof of Medicare exhaust
• Write “Medicare Exhaust” on UB-04
Top Five Edits

- 1108 – Billing NPI has no matching LPI
- 1102 – Billing NPI must be submitted
- 1112 – Referring/PMP NPI must be submitted
- 4095 – Non-surgical services are not reimbursed individually
- 0558 – Coinsurance and deductible amount missing
Modifications to Duplicate Logic

• IndianaAIM now reads all five digits of the procedure code and all modifiers
• Applicable to claims and replacement claims received on or after September 27, 2007
• Applicable to the following claim types:
  – Medical
  – Medical Crossover Part B
  – Outpatient
  – Outpatient Crossover C
  – Home Health
• Effective August 1, 2007:
  – Crossover claims billed on a CMS-1500 claim form no longer deny with edits 5007 (exact duplicate, header), or 5008 (suspect duplicate, header)
  – These claims now emulate the possible, and exact duplicate logic applied to medical claims, which apply the 5000 (possible duplicate), and 5001 (exact duplicate) edits
Modifications to Duplicate Logic

Example 1:

10/25/07  73560 LT
10/25/07  73560 RT

Example 2:

10/26/07  H0044 HW HQ AH
10/26/07  H0044 HW HQ HE

The second detail line will no longer deny as a duplicate to the first detail line.
Helpful Tools
Avenues of Resolution

- IHCP Web site at www.indianamedicaid.com
- *IHCP Provider Manual* (Web, CD-ROM, or paper)
- *MRO Provider Manual*
- Customer Assistance
  - Local 317-655-3240
  - All others 1-800-577-1278
- Written Correspondence
  - EDS Provider Written Correspondence
  - P. O. Box 7263
  - Indianapolis, IN 46207-7263
- Provider Field Consultant
Questions