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Provider Memorandum

Common Facility Billing and Encounter Errors

Molina Healthcare of Illinois (Molina) wants to be sure its Members get the care they need. Molina is grateful to its providers for helping Members and supplying high quality health care. Recently, Managed Care Organizations (MCO) and the Illinois Department of Health and Family Services (HFS) issued a statement to provide clarification on the facility billing requirements for covered and non-covered days.

In accordance with the Illinois Department of Health and Family Services (HFS) Chapter 200, Hospital Handbook and Hospital Appendices, providers are required to bill the appropriate value codes in relation to the Member's admitted stay.

Statement and Admission

Statement covered days, also known as "from and through" dates, must be the correct date that the Member was admitted or when the services were rendered, as illustrated in the decision tree below:

- The statement covers periods ("from" and "through" dates in Form Locator 6) and identifies the span of service dates included in a particular bill. The "from" date is the earliest date of service on the bill.
- The "through" date on an outpatient claim must not be after the admit date on an inpatient claim.
- The admission date (Form Locator 12) is the date the patient was admitted as an inpatient to the facility (or indicates the start of care date for home health and hospice). It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill.
- On an interim continuing (XX3) or interim final (XX4) bill, the admit date must be prior to the statement covers "from" date. (Interim claims are not allowed for general acute care. Bills must be submitted for the entire stay).

IF…	THEN…
Member was seen for only outpatient services on a single day.	Statement covered dates would be the same and no admission date would be billed.
Member was first seen in the emergency department / observation, then admitted later that day and provider is billing a single claim.	Statement covered dates would begin the day the Member was first seen in the emergency department and admission date would be the same.
Member was first seen in the emergency department (ED)/ observation, then admitted and provider is billing two separate claims.	Hospitals have the option to bill, in addition to the inpatient claim, one outpatient claim containing the emergency room charge or the observation room charge only. All ancillary services related to the emergency or observation department services are reported on the inpatient claim. **First Claim:** Statement covered dates would include only the days Member was in the emergency department with no admission date. **Second Claim:** Statement covered day would begin on the next day Member was admitted. Admission date would match that date. Correct and valid admission source code should be submitted.

EDI/ 837I Requirements:

- Admission date is required on ALL inpatient institutional bill types and should be no later than the "from" date on the initial provider claim.
- Paper UB claim placement = FL/Box 12 (No future dates)

- EDI claim placement = Loop 2300, DTP*435 in the DTP03 segment (No future dates):
  (Claims require the "DT"- date/time format qualifier for all Inpatient, Hospice and Interim Inpatient claims, in the DTP-02, and the date/Time in the CCYYMMDDHHMM format in the DTP03 segment) - (LTC can use the D8-date qualifier in the DTP-02, without the time elements of hours and minutes):
  - Example with hours and minutes: DTP*435*DT*201705171205
  - Example without hours and minutes: DTP*435*D8*20170517

VALUE CODES

All inpatient and Long Term Care (LTC) claims must report the covered and non-covered days and coinsurance days where applicable.

Value codes vary and are comprised of two data elements; the value code and the amount. They are used to report the following information (if applicable):

- Locator Code
- Rate Code
- Recurring Monthly Income
- Other Insurance Payment
- Newborn Birth weight
- Epogen units
- Medicaid Covered Days
- Medicaid Non-Covered Days
- Medicare Co-Insurance Days

The following value codes are to be reported when required or applicable:

Value Code	Description
Value Code 23 (Patient Credit Amount)	Value Code 23 should be used to indicate that the patient's credit amount and is entered under amount.
Value code 54 (Newborn Birth weight in grams)	Beginning with admissions October 1, 2012 and after, Value Code 54 is required for newborns who are 14 days of age or less on the date of admission. This Value Code is to be reported with the baby's birth weight in grams, right-justified to the left of the dollar/cents delimiter, and will be used in the APR-DRG determination.
Value Code 68 (Epogen Units)	Value Code 68 must be used when Erythropoietin (Epogen) is billed under revenue codes 0634 or 0635 in addition to using the correct units of measurement.
Value Code 80 (Covered Days)	Value Code 80 must be used to indicate the total number of days that are covered. The Covered Days must be entered to the left of the dollars/cents delimiter.
Value Code 81 (Non-Covered Days)	Value Code 81 must be used to indicate the total number of full days that are not reimbursable. Enter the actual number of Medicaid non-covered days to the left of the dollars/cents delimiter. An occurrence span code of 74 must also be billed in HI*BI segment (FL 35-36) to indicate a non-covered level of care or a leave of absence.
Value Code 82 (Medicare Co-Insurance Days)	Value Code 82 should be used when primary insurer is Medicare and indicates the total number of Medicare co-insurance days claimed during the service period.

Covered and Non-Covered Days

In accordance with the Healthcare and Family Services, Bureau of Information Services, *Chapter 300 837i companion guide*, all inpatient and LTC claims must report the covered and non-covered days and coinsurance days where applicable.

For Illinois Medicaid outpatient series claims, the number of series days for which outpatient services were provided must be reported in loop 2300 with a Value Code of "80" and the number of series days billed. Hospitals will be able to bill multiple APL

groups on a series claim. All claims must contain a series-billable revenue code and a series-billable APL code for each service date billed. Value code 80 is still required to identify the number of covered days.

The sum of covered and non-covered days, must correspond to the Statement Covers Period in Form Locator 6 and should not reflect the day of discharge unless billing an interim claim for hospice or long term care or billing an expired status code.

Claims paid by Per Diem reimbursement should have the appropriate covered and non-covered days reported to match the authorization.

Examples of how to report covered and non-covered days on hospital claims:

- On claim level, report total length of stay which is service from to service through (e.g. 07/10/2017 – 07/19/2017)
    - DTP*434*RD8*20170710-20170719

- Number of days of stay does not include day of discharge (DOS through Date – DOS from Date)
    - Report non covered dates on HI*BI segment with occurrence span code 74
        - HI*BI: 74:RD8:20170715-20170718

    - Report covered and non-covered days on HI*BE segment with value code 80 for covered days and 81 for non-covered days
        - HI*BE:80:::5*BE:81:::4*BE:01:::19.29

- On service lines level, Units reported with accommodation revenue codes must be equal to total number of covered days

    - SV2*0120**9645*DA*4
    - DTP*472*RD8*20170710-20170719
    - LX*2
    - SV2*0202**4245*DA*1
    - DTP*472*RD8*20170710-20170719

- For following patient status codes, date of discharge is counted when patient is in deceased status. Report one of these status codes only for Hospice and LTC claims (DOS through Date – DOS from Date) +1

    - 20-29 Expired
    - 40 Expired at home
    - 41 Expired in medical facility (e.g. hospital, SNF, ICF, or free standing hospice)
    - 42 Expired – place unknown

Interim claims

Any facility that is reimbursed per Diem should bill admission thru discharge on these interim claims. Providers need to ensure correct right bill type, frequency code, admission and statements dates for each bill. Interim claims for DRG reimbursed facility charges are not to be billed. A single claim for the entire period covering admit through discharge should be submitted.

- Patient status 30 must be billed for interim claims
- If Bill frequency type code (On CLM Segment) is a 1 or 4 – Do not calculate day of discharge in covered-non covered day calculations
- If Bill frequency type code is 2 or 3 – Include day of discharge in covered-non covered day calculations.

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Please find description below.

1 Admit through Discharge Claim = (DOS through date – DOS From Date)
2 Interim-First Claim = (DOS Through date – DOS From Date) +1
3 Interim - Continuing Claim = (DOS through Date – DOS From Date) +1
4 Interim-Last Claim= (DOS through Date – DOS From Date) **Frequent rejection reasons / other UB04/837 Institutional claim type submission reminder items:**

Topic	Denial/Rejection Reason
Missing Covered Days	Inpatient or series billable claim submitted without Value code 80/amount
Invalid Covered days for Renal Dialysis	For all Outpatient Bill Type 072X, where date of service is 6/1/2016 and after, and claim has Revenue Codes 0841 or 0851 at line level, and Value code 80 and amount are not submitted
Incorrect/Missing Non-covered days	Inpatient claim submitted where difference between Statement From Date and Through Date for Occurrence Span Code 74 doesn't match with Non-Covered Days Value Code submitted, or, when Value code 81/amount not submitted for the days that were not covered
Accommodation Days are not equal to covered days.	Total accommodation days billed do not match the total covered days the claims will reject.
Service units greater than covered days.	The sum of Service Units in claim line level is greater than or not equal to Covered days value code 80 amount(s).
Missing/invalid Value code for series claim	Series billable claims do not contain Value code 80 and the amount of days being billed
Procedure Date Outside Per Diem Range	Inpatient claim submitted where Procedure Date is not within the From and Through dates
Illogical Patient status code for Billing status	Inpatient claim (or outpatient series claim) submitted where Type of Bill indicates patient still hospital inpatient, or residing in a nursing facility, or patient coming back for treatment, while Patient Discharge Status indicates patient was discharged.
Invalid Interim Claim	An interim claim was received from a DRG Hospital for general inpatient and must be billed for the entire period covering admit through discharge.

For further HFS-specific submission requirements please refer to the Chapter 300 837i companion guide link.

Providers who have questions or concerns on the admission date and value code billing guidelines may contact their Provider Network Manager or the Network Management Team at (630) 203-3965 or via email at IllinoisProviders@MolinaHealthcare.com.