

4. Billing Medicaid

Contents

4.1	About Medicaid Billing.....	4-2
4.2	Medicaid Approval and Export Process.....	4-2
4.2.1	Example of Electronic Claim Submission for Medicaid.....	4-3
4.3	Medicaid Timely Filing.....	4-3

4.1 About Medicaid Billing

The Centers for Medicare/Medicaid (CMS) is the regulatory agency for Medicare, Medicaid, and Managed Care Organizations. It is mandated that each facility submit electronically, Medicare and Medicaid claims in the HIPAA 837 format.

CMS has assigned each state to develop and operate its own Medicaid program.

Medicaid regulations are set forth I Title XIX of the Social Security Act. CMS has determined that IHS hospitals and clinics will bill Medicaid at current per diem rates according to the Federal Register for inpatient and outpatient visits (one visit per day). For hospitalizations, professional fees can be billed to Medicaid; however, each state determines the fee schedule that will be used.

Each state provides different benefits and eligibility packages for their population. Please contact your state for specific information. In addition, each Medicaid insurer provides a reference manual on setting up and submitting electronically.

4.2 Medicaid Approval and Export Process

- Review the inpatient or ambulatory surgery abstracts received from Utilization Review. Verify that abstract forms are complete and accurate.
- Review the RPMS Third Party Billing system “flagged as billable” report for inpatient, outpatient and ambulatory billing. This report is a review of claims automatically flagged by the nightly claims checker that are ready for billing.
- Bill according to the state’s billing format.
- Review claim data for accuracy and completeness.
- Any issues with coding, system problems, or missing information needs to be corrected before approval.
- Approve and export claim.

There are various ways of submitting claims electronically. Refer to your State Medicaid guidelines for batching and submitting claims electronically.

4.2.1 Example of Electronic Claim Submission for Medicaid

This is a typical procedure for exporting batches of claims to Medicaid.

1. Review electronic claims menu, noting the number of claims submitted, number of claims eligible for submission, and claims referenced in the error report.
2. Review pre-bill listing prior to submission of claims electronically.
3. Transfer approved claims to the directory in the host file server (HFS).
4. Each type of bill (inpatient, outpatient, or ambulatory surgery) will be processed individually by selecting the appropriate listed option. A separate file will also be created by location.
5. Assign an appropriate file name to the selected type of bill.
6. Use File Transfer Protocol (FTP) software to transfer files to desktop or local PC, and then submit electronically in the correct transfer mode format.

4.3 Medicaid Timely Filing

Most claims for services submitted to Medicaid must be submitted within the state required guidelines; for example, New Mexico Medicaid has a timely filing limit of within 120 days of the date the service. Some states require transmission as early as within 90 days.

Requests for adjustments to rejected or denied claims must be submitted within the State guidelines; for example, New Mexico Medicaid requires that providers submit claims within six (6) months of the date on the “remittance advice” form which accompanied the payment or denial of the claim.

Follow your State requirements for finalizing claims.

These are examples of exceptions to general time limitations for Medicaid submission:

- If claims are submitted more than 120 days after the date of service, the statement of benefits from the other insurance or the denial of benefits from the other insurance must be attached to the claim to verify that the other payment source has been pursued.

- If a provider receives payment from the other insurance or liable third party after receiving payment from Medicaid, an amount equal to the lower of either the insurance payment or the amount paid by Medicaid must be immediately remitted to Medicaid.
- Claims for services furnished by out-of-state providers must be submitted within 120 days (or the timeframe authorized by the state Medicaid, if different) of the date of service. In the event the out-of-state provider does not have a Medicaid provider number for that state, the request for the provider number must also be submitted within the 120-day limit.
- Claims for services provided during a period for which retroactive eligibility has been established must be submitted within 120 days (or timeframe authorized by that state Medicaid) of the date the Medicaid claims processing area was notified of the retroactive eligibility.
- Corrected claims which are originally submitted within the timely filing limit and need corrections or additions must be completed and submitted to Medicaid or its claims processing area within 365 days of the date of service.
- Duplicate claims which are used to replace lost or unprocessed claims must be submitted within the same timeframe as an original date of service claim.