

PROVIDER BULLETIN

No. 11-30

Date: June 8, 2011

TO: Hospitals

FROM: Vivianne M. Chaumont, Director 
Division of Medicaid & Long-Term Care

BY: Margaret Booth, Administrator I
Division of Medicaid and Long-Term Care

RE: Reporting ICD-9 Codes on Inpatient Hospital Claims

PLEASE SHARE THIS INFORMATION WITH ADMINISTRATIVE, CLINICAL AND BILLING STAFF.

Our current Medicaid Management Information System (MMIS) only recognizes up to nine diagnosis codes and six surgical codes on a claim. When you submit a claim with more than nine diagnoses and/or six surgical codes the MMIS will only process the first nine diagnoses and six surgical codes for purposes of assigning a Diagnosis Related Group (DRG) for payment.

This has particularly been identified in the case of neonatal claims where the weight of the infant is not among the first nine diagnoses on the claim. In these cases, the MMIS defaults to a birth weight of >2499 Grams which may affect the DRG assignment.

It is recommended that you work with your coders regarding the sequencing of codes.

To request an adjustment to a claim that has already been submitted, you must indicate on the remittance advice the ICD-9 code(s) you want added and the one(s) you want deleted. Simply sending in a different DRG number will not allow an adjustment to the claim.

Providers must submit claim adjustment requests within 90 days of the payment/denial date on the Medicaid Remittance Advice.

If you have any questions regarding this bulletin, please contact Margaret Booth at 402-471-9380 or margaret.booth@nebraska.gov.