Biller “B”Aware Archives

Resolved Issues

• **December 7, 2009 -** LOCDs must be entered online according to Medicaid Policy which can be found in the Medicaid Provider Manual, Nursing Facility Chapter, Section 4.1D. The Manual is posted online at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual
CHAMPS validates the LOCD creation date to the date of beneficiaries' Medicaid start date as determined by DHS. If a LOCD was created contrary to policy, you will receive an error message while trying to enter the beneficiary ID.
Please note, if a beneficiary's application for Medicaid is denied, you will need to create a new LOCD when a new application is submitted.

• **November 23, 2009 -** Urgent/Emergent Adult Dental Claims Denying with CARC 17 and RARC N379: In July, non-emergency dental benefits were eliminated for Medicaid beneficiaries 21 and over (Executive Order 2009-22). Only a few specific
urgent/emergent dental services are currently billable for beneficiaries 21 and older. Claims for beneficiaries 21 and over receiving urgent/emergent dental services were being denied in CHAMPS with the reason code 17 and remark code N379. There are three errors here:
- First, the urgent/emergent dental services should not have been denied. This has now been corrected and providers may rebill or replace any affected claims by either HIPAA 837 or via the CHAMPS Manage Claims screens.
- Second, if the services were in fact non-emergent then the claim denial should have had a different HIPAA reason and remark code explanation. The change necessary to display the correct CARC and RARC when non-urgent/emergent adult services are billed is scheduled to be corrected in December.
- Third, the only exception for continued payment of the non-emergent services was if the provider had a current prior authorization on file with MDCH prior to the implementation of Executive Order 2009-22. These claims are still being denied in error and should be held by providers until this correction is completed. Further guidance will be shared when an exact implementation date is known.

• **November 23, 2009 -** Dental Procedure Code Correction: The combination of procedure code D1351 and tooth number 19 was not recognized. This has now been corrected and Providers may rebill.

• **November 23, 2009 -** General Procedure Code Corrections: CPT 96372 (Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular) was missing a rate segment which has now been restored. Providers may rebill or replace any affected claims involving CDT D1351 or CPT 96372 through either the HIPAA 837 or via the CHAMPS Manage Claims screens.

• **November 20, 2009 -** Medicare crossover claims are current in CHAMPS and are being processed for the month of November, 2009. These claims will be listed on remittance advices. The remittance advice(s) will reflect the paid and denied claims. If you believe there are still missing claims, please contact

providersupport@michigan.gov

• **November 20, 2009** - Between the hours of 6am and 6pm on Sunday, November 22, 2009, the CHAMPS system is scheduled for routine maintenance. The system will be unavailable until the maintenance operations have been completed.
• **November 6, 2009 -** With CHAMPS implementation the payment to providers at tax ID level is including all Capitation payments with the Fee for Service (FFS) payments. All capitation payments can be viewed from the 820's that are produced and transmitted. The FFS payments can be viewed from the Remittance Advice found in Archived Documents in CHAMPS. If you have questions regarding your 820 information, please contact your CMH or MCO Contract Manager.
• **November 5, 2009 -** The CHAMPS generated paper remittance advices (RA) can be found in the "Archived Documents" link located on the Provider Portal page or "My Inbox" subsystem. Only those users with the profile of CHAMPS Full Access or CHAMPS Limited Access will have the ability to view this information. Paper RAs will be stored in CHAMPS for approximately three months. These documents are available to print or save for your records. In addition, MDCH was aware of missing RAs from remittance advice date 10/07/2009, this issue has been resolved. If providers feel they are missing a RA within this link, please contact provider support at providersupport@michigan.govor 800-292-2550.
• **November 4, 2009 -** Prior Authorization Numbers in CHAMPS: Providers have been experiencing a range of issues related to the use of prior authorization numbers on their claims. There were some changes to the format of the number. Pre-existing PA numbers remained their original 9-digits (i.g. 999999999). Pre-existing PACER numbers will appear in the PA system with the letter M added to the beginning, making them 10-digits (i.g. M999999999). The M was necessary to maintain the uniqueness of the PACER numbers as they were combined into one database with authorizations from other business areas. Providers should not include the M when billing though the 'M' is necessary when querying the CHAMPS PA system. New Prior Authorizations and PACERs created in CHAMPS are now 10-digits, all numeric (i.g. 1111111111). These new PAs should be reported as 10-digits on claims.

MDCH is also investigating issues related to billing multiple lines of prior authorized services. Currently providers are reporting that only the first line is being paid and subsequent claim lines are being denied. Providers will continue to be informed of resolutions to these issues as soon as they have been finalized.
• **November 4, 2009 - Attention Institutional Billers- Updated 11/14/09:** Evaluation and management CPT codes reported on institutional outpatient claims with modifier 25 or 59 have been denied in error. After the issue has been resolved, MDCH will recycle the affected claims for proper adjudication.
• **November 4, 2009 -** Executive Order 2009-22 - Elimination of Certain Medicaid Benefits for Adults 21 years & older: In July, dental benefits were restricted for

adults 21 years and up to certain urgent/emergent services only. **Vision, hearing, chiropractic, and podiatry services were also eliminated for adults 21 years and over (See MSA Bulletin 09-28 for details).** Currently, there is an issue with the editing of these claims for age and date of service. MDCH will reprocess the affected claims upon correction of system logic. The Claim Adjustment Reason Code (CARC - 17) and Remittance Advice Remark Code (CARC - N379) reported for these denials was also incorrect. These issues are being addressed separately. A complete review of CARC and RARC reported on remittance advice is underway and the updates to the system are expected to be finalized in December.

• **November 4, 2009 -** **Attention CMH Providers:** Currently, claims for psychotropic injectables are being denied in CHAMPS because the combination of billing and rendering NPI on the claim is not recognized as appropriate for the specific procedure codes being billed. This is an internal coding issue that MDCH is addressing. MDCH will add a new specialty to all fee-for-service CMH enrollments in CHAMPS so that CMHs currently enrolled as Children's Waiver and/or SED Waiver agencies can bill for psychotropic drugs also. MDCH must also add the specialty to claims adjudication and financial management logic. All of the necessary changes are expected to be complete in early to mid-December. After completion, MDCH will reprocess all of the affected claims. Claims for psychotropic injectables submitted with a billing NPI that is enrolled as only a Medical Group are not experiencing this issue and can continue to be billed. When billing for psychotropic injectables, the rendering provider on the claim must be actively enrolled in CHAMPS as a physician and associated to the billing NPI on the claim.

• **October 26, 2009 -** CHAMPS Claims Editing- Level of Care Determination (LOCD): MDCH is temporarily suspending the claims editing related to the LOCD that occurred with the implementation of CHAMPS. This editing was the result of an unanticipated interaction between the new system and the level of care determination tool. We are aware of the multiple issues providers are struggling with as both CHAMPS and Bridges are implemented and hope that this action will remove one of the barriers to reimbursement. It is important, however, that providers continue to perform the LOCD according to policy and enter it in the on-line system to ensure that beneficiaries do indeed meet the medical/functional level of care requirement for reimbursement. Notification will be issued prior to the claims editing for the LOCD being reactivated. The department will continue to work toward resolution of the implementation challenges and we thank all of you for your assistance and patience.

• **October 19, 2009 -** MDCH has identified an issue with secondary claims paying $0 in error. Once the issue has been resolved, MDCH will be reprocessing the affected claims.

• **October 14, 2009 -** Attention Providers: The pay cycle number on MSA [paper] Remittance Advice and electronic 835 Remittance Advice may have been incorrect for the last two pay cycles (39 and 40). This issue will be resolved as soon as possible. In addition, during the first full pay cycle processed in CHAMPS (Pay Cycle 39), RAs were generated on several different days causing

different pay dates to be listed for that week, the earliest date being 09/26/2009. To ensure that no remittance is overlooked, providers and billing agents should use a range of pay dates to find all paid claims and remittance advices.

• **October 13, 2009 -** DCH has identified an issue of incorrect HIPAA Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) being reported on providers' remittance advices. The most prevalent code is CARC- 110 - (Billing date predates service date). Any questions regarding this HIPAA CARC code may be directed to the Provider Support Line at ProviderSupport@michigan.gov. MDCH is undergoing a review of all the affected CARC and RARC codes and will resolve the issue as soon as possible.

• **October 5, 2009 -** MDCH has identified a difference in the way that the legacy MMIS system and CHAMPS reports the payment for providers that receive Medicaid Interim Payments (MIP) or are Warrant Suppressed.
Currently, the approved amount for any MIP or Warrant Suppressed claim lines will incorrectly show as $0.00 within the 835 and Paper RA. For the 835, each individual line will report this approved amount within the CAS segment with Claim Adjustment Reason Code (CARC) 94, Processed in Excess of charges. This is the only time MDCH will use CARC 94, therefore any claim that has CARC 94 within the 835 will be for a MIP or Warrant Suppressed claim. The approved amount within the Claims Inquiry screen in CHAMPS will show the actual approved amount.

MDCH will be fixing this information to have it report correctly as soon as possible and will send out another update as soon as this issue is resolved. If you have any questions, please contact Provider Support at 1-800-292-2550 or ProviderSupport@michigan.gov.

• **September 30, 2009 -** Attention Professional Billers: In accordance with the Executive Order 2009-22, the Michigan Department of Community Health (MDCH) eliminated certain covered service benefits for Medicaid beneficiaries age 21 and older, and implemented program/fee reductions effective for dates of service on and after July 1, 2009. Currently claims that are affected by this Executive Order are denying incorrectly in CHAMPS. After the issue is resolved, MDCH will recycle all of the affected claims so that services are properly adjudicated. Please contact the Provider Inquiry at 1-800-292-2550 regarding cash flow concerns. For more information regarding the programs and services affected by Executive Order 2009-22, please refer to MSA Bulletin 09-28.

• **September 28, 2009 -** Beginning Tuesday, September 29, 2009 the Automated Voice Response System (AVRS) service through Emdeon will no longer be available. Please contact Emdeon with questions regarding the discontinuation of this service.

• **September 24, 2009 -** There are some remaining PDN claims in MI AuthentiCare that were exported for payment after the cutoff date of September 9, 2009. These claims will need to be resubmitted into CHAMPS. To determine if this issue applies to you, log onto CHAMPS and check your claims to identify if any of your claims are affected. If so, the affected claims will need to be

resubmitted through CHAMPS.

• **September 17, 2009 -** In preparation for the Friday, September 18th release of CHAMPS (Community Health Automated Processing System) to the public, MDCH began redirecting claims from the Legacy MMIS to CHAMPS on Monday, September 14th. MDCH has been closely monitoring CHAMPS to ensure that claims are adjudicating appropriately. Any issues are tracked and, if possible, resolved immediately. MDCH has identified and corrected an issue with some Medicaid Interim Payment (MIP) indicators. Those claims treated incorrectly will be tracked and resolved at reconciliation or settlement.

• **September 16, 2009 -** In preparation for the Friday, September 18th release of CHAMPS (Community Health Automated Processing System) to the public, MDCH began redirecting claims from the legacy MMIS to CHAMPS on Monday, September 14th. MDCH has been closely monitoring CHAMPS to ensure that claims are adjudicating appropriately. Any issues are tracked and, if possible, resolved immediately. MDCH has identified an issue with certain void claims that providers should be aware of, though.

As announced previously, claims that were billed in the legacy MMIS (with what is now a Rendering/Servicing-Only Individual NPI in CHAMPS) have been migrated to CHAMPS with all other paid and denied claims for historical purposes but they cannot be adjusted/replaced. If these claims need to be adjusted/replaced, providers must first void the original claim and then rebill the claim as a new original claim with the appropriate billing and rendering NPIs. The void process for these types of claims has not been fully automated in CHAMPS yet and is expected to be fully functional in early November.

During the first day of adjudication in CHAMPS, MDCH staff identified a significant number of void and replacement claims that were incorrectly denied by CHAMPS for one of two reasons: the original claim was billed with a Rendering/Servicing-Only Individual NPI. (or) the billing NPI on the adjustment/void claim did not match the original claim because the adjustment or void claim now has a proper billing NPI though the original claim only had a Rendering/Servicing-Only Individual NPI.

MDCH has now resolved the error that caused these claims to deny. If a void claim is submitted for an original claim that meets this criteria, the claim will suspend until the process has been automated, at which time MDCH will force the claims back through the adjudication process. Providers have the choice of holding back these types of void claims or submitting them now so that they will suspend until the process has been automated.

• **September 14, 2009 -** MDCH is excited to announce that CHAMPS is now adjudicating 837 files directly. CHAMPS will not change the way that any Trading Partners submit or transfer claims. CHAMPS will communicate directly with the DEG to receive any files that have been uploaded through the DEG.

Any files submitted to the DEG September 10, 2009 through September 13, 2009 have been on hold and these will now be moved to CHAMPS. You may have originally received an accepted 997 from legacy, but now that these files will be moved into CHAMPS you will receive an additional 997.

Any new files submitted will receive the single 997 from CHAMPS. MDCH will be closely watching any new file transmissions into CHAMPS, therefore providers may not receive a 997 instantaneously.

• **September 10, 2009 -** CHAMPS HIPAA File Submission Update: Due to the implementation of the CHAMPS system, all providers submitting 837 files will need to ensure that they are following HIPAA guidelines. Please review the updated CHAMPS HIPAA Companion Guides located on the CHAMPS website at www.michigan.gov/MDCH >>CHAMPS>>Resources. Failure to adhere to HIPAA guidelines will result in a rejected 997 acknowledgment file.

• **September 10, 2009 -** Migration of Legacy Suspended Claims into CHAMPS Reminder: Projected to begin October 1, 2009 MDCH will initiate the process of resurrecting all claims that rejected with proprietary edit 743 for adjudication in CHAMPS. Claims will not be recreated in CHAMPS if any of the following occur: the claim was submitted without a reported billing NPI, the rendering/servicing only NPI was incorrectly reported in the billing NPI loop/field, or the provider has not revalidated in the CHAMPS Provider Enrollment subsystem. These resurrected claims **will not** be available for inquiry in CHAMPS until after the projected date.

• **September 10, 2009 -** Attention Providers: Please view this CHAMPS Go-Live informational announcement .

• **September 9, 2009 -** Per Policy Bulletin 09-48, as of 9/10/09 Private Duty Nurse providers will no longer be able to use MI AuthentiCare to bill Medicaid. PDN providers must be ready to bill Medicaid directly as of September 10, 2009. MI AuthentiCare will not be available after 9/9 at 12 midnight.

• **August 11, 2009 -** Please be advised: Due to the transition from the legacy Medicaid Management Information System (MMIS) to the Community Health Automated Medicaid Processing System (CHAMPS) there will be no Medical Services Administration (MSA) payments made on pay cycle 38, pay cycle date 9/23/09. Pay cycle 39, pay date 9/30/09 will include payments for both pay cycle 38 and pay cycle 39.

Hospital Medicaid Interim Payment (MIP) program payments and Quality Assurance Supplement (QAS) payments for Long Term Care Facilities that were originally scheduled for pay cycle 38 will be processed on pay cycle 37, pay date 9/16/09, a week early.

In the event that issues arise during pay cycle 39, MDCH will implement and communicate a process to mitigate the impact on providers.

• **August 11, 2009 -** Attention: MDCH would like to remind those providers currently submitting paper claims that it is recommended that all paper claims be

submitted electronically or through the Direct Data Entry (DDE) tool in CHAMPS beginning September 18, 2009. All Institutional providers must report 4 digit (leading zero) Revenue Code and Type of Bill. MDCH will no longer accept the 3 digit codes when billed.

• **July 30, 2009 -** Please note: To access the CHAMPS system, all users must have a Single Sign-On (SSO) user ID and password. Please see the SSO instructions on how to obtain this. The Provider Domain Administrator will have responsibility of assigning rights for all other users within the organization to access the provider's file. If necessary, multiple Provider Domain Administrators may be established for a single organization but a separate application must be completed and approved for each administrator.

There are several profiles that may be assigned to each user within CHAMPS. Profiles must be established to grant access to the subsystems within CHAMPS. Users may have multiple profiles if necessary.

Below is a list of the profiles that are available for assignment only, but will not have system access until September 18, 2009:

- Domain Administrator - The ability to assign or remove domain and profile access to other CHAMPS users
- CHAMPS Full Access - Full Fee for Service access to Provider Enrollment, Prior Authorization, Eligibility, and Claims subsystems
- CHAMPS Limited Access - View only access to Provider Enrollment and full Fee for Service access to Prior Authorization, Eligibility, and Claims subsystems
- Prior Authorization Access - Fee for Service access to Prior Authorization only
- MCO Provider Access - Access to Managed Care Organization Provider Enrollment only
- Eligibility Inquiry - Fee for Service access to Eligibility only
- Provider Enrollment Access - Fee for Service full access to Provider Enrollment only
- View Provider Enrollment - View only access to Provider Enrollment
- Billing Agent Access - Access to Billing Agent Provider Enrollment only
- Claims Access - Full Fee for Service access to Claims only

• **July 30, 2009 - Please be advised:** As part of the CHAMPS implementation plan, Michigan Department of Community Health (MDCH) will not allow any system changes or updates beginning August 28, 2009 through September 17, 2009. This includes any new enrollments or modifications to existing applications as well as any Domain Administrator functions. Please be aware that all changes or modifications must be completed prior to August 28, 2009 or on or after the Go-live date of September 18, 2009.

• **July 29, 2009 - Please be advised:** As part of the CHAMPS implementation plan, Michigan Department of Community Health (MDCH) will need to migrate all

existing suspended claims within the current legacy system into CHAMPS. To accomplish this, a phased approach will be used to reject these claims in the legacy system and later resurrect them in CHAMPS.

Beginning August 12, 2009 (Pay Cycle 32), any suspended claims that have duplicates will be rejected with:

- Proprietary edit 713 (Claim rejected as it is a duplicate of another suspended claim. Do not resubmit.)
- Claim Adjustment Reason Code (CARC) 18 and Remittance Advice Remark Code (RARC) N185

The oldest original claim will remain suspended in the legacy system. There is no need to submit a new claim.

Any remaining suspended claims in the legacy system will be rejected August 26, 2009, (Pay Cycle 34) through September 9, 2009 (Pay Cycle 26) with:

- Proprietary edit 743 (Claim manually rejected due to technical reasons._
- CARC 101 and RARC N185

As stated above, please do not resubmit these claims as they will be migrated into CHAMPS.

NOTE: Any claims submitted into the legacy system on or after August 20, 2009, if they suspend, will be automatically rejected with edit 743 and transferred into CHAMPS.

The legacy system will continue to accept and process claims during this transition period until September 9, 2009 at which time the adjudication system will be closed to prepare for CHAMPS implementation.

For further details, please refer to MDCH Numbered Letter, L 09-19, or contact Provider Support through the toll-free phone number at 1-800-292-2550 or via e-mail at ProviderSupport@michigan.gov.

• **July 18, 2009-** MDCH has identified a systems issue with Inpatient claims incorrectly paying Patient Status 43, 62 & 65. MDCH will be initiating claim adjustments for any claim with Patient Status 43, 62 or 65 with admit dates on/after 1/1/2007. These adjustments should appear on Pay Cycle 29 - RA 7/23/09.
• **June 22, 2009 -** As a result of Executive Order 2009-22 mandating State of Michigan furlough days, you could experience a delay in Medicaid payment. To avoid a delay, claims must be submitted one day earlier than the normal schedule. Please be aware, claims must be submitted by noon June 29, 2009 in order to appear on pay cycle 27, dated July 8, 2009.

• **June 16, 2009 -** The April 15, 2009 Biller "B" Aware message instructed providers to submit the Medicare EOB when reporting the Medicare Part C deductible in error. Submission of EOBs is only required when documenting the billing time limit, non-standard payments for traditional Medicare, or for secondary paper claims. When billing electronic claims EOBs are not required when billing Medicare Part C (Medicare Advantage or HMO) or traditional Medicare claims with standard payments. Submitting EOBs will not replace the requirement for CAS codes. Claims without appropriately completed CAS codes will be rejected.
• **May 12, 2009 - Please be advised:** Medicaid will no longer accept CO 42 (Contractual Obligation) for all Out Patient Hospital (OPH) Claims as this was end dated as of June 2007. In replacement all providers should use the CO 45 when reporting Contractual Obligations. Please make the necessary changes to all OPH claims submitted regardless of the date of service.
• **May 6, 2009 - Attention Rendering/Servicing Providers:** Many providers billing within the professional claim format are reporting the same NPI in both the billing provider and rendering provider loops/fields. This is not correct. If you are a rendering/servicing provider who renders services on behalf of a group, the biller MUST report the GROUP NPI (Type 2 NPI) in the billing provider loop. Currently, within the legacy system, rendering/servicing only providers are incorrectly receiving payment. This will not happen when CHAMPS goes live, payments will stop if the claims continue to be billed incorrectly!

Within the professional claim format, providers enrolled as rendering/servicing only must report the-group NPI of the billing provider (Type 2 NPI) in Loop 2010AA , Segment NM108, Qualifier 85 for electronic claims (or) Field 33a on the CMS 1500 paper claim form. The rendering provider (Type 1 NPI) must to be reported in Loop 2310B, Segment NM108, Qualifier 82 for electronic claims (or) Field 24J on the CMS 1500 paper claim form.

Within the dental claim format, providers enrolled as rendering/servicing only must report the group NPI of the billing provider (Type 2 NPI) in Loop 2010AA for electronic claims or Field 49 on the ADA 2006 paper claim form. The rendering provider NPI (Type 1 NPI) has to be in Loop 2310B for electronic claims or Field 54 on the ADA 2006 paper form.
• **May 1, 2009 - Attention Outpatient Hospital Providers:** The MDCH has implemented Medicare specific quantity editing. Claims will reject when the reported quantity exceeds Medicare's expected allowable. Rejection code 294R will appear on the line and 841R at the header.
• **April 30, 2009 - Please be advised:** Providers who have not completed their Provider Enrollment revalidation in CHAMPS will be end-dated in the Legacy System effective May 1, 2009. Any services provided on and after this date will result in claim rejections. Providers that are end-dated and wish to re-activate their enrollment will need to contact the CHAMPS helpline at 888-643-2408 or CHAMPS@michigan.gov
• **April 27, 2009 -** Due to a systems error the MDCH will initiate claim adjustments for Inpatient Hospital Medicare Secondary claims for dates of service back to 2007, which

were paid incorrectly. Hospitals were underpaid because of incorrect logic in the Medicare payment/lesser of determination. We apologize for any inconvenience this may have caused.

• **April 23, 2009 - Attention Inpatient Hospital providers:** At a recent Hospital Work Group meeting providers were informed in Community Health Automated Medicaid Processing System (CHAMPS) they would need to enumerate their Inpatient services separately to receive Medicaid Interim Payments (MIP). Due to a large provider response, MSA is pursuing an enhancement to CHAMPS which will **not** require NPI re-enumeration for MIP.

• **April 22, 2009 -** Due to systems issues, the April Medicare reports from Third Party Liability (TPL) will not be able to be sent out. We apologize for any inconvenience this may have caused.

|• **April 17, 2009 - Attention Outpatient Hospital providers:** Systems changes to implement January 2009 OPPS/APC updates have been completed. Claims with February 2009 dates of service have been adjusted and will appear on the remittance advice dated 4/22/09, pay cycle 16.

• **April 17, 2009 - Attention inpatient hospital providers:** A systems error has been identified which caused incorrect adjudication of secondary claims when Medicare part "A" exhausted Medicaid made $0.0 payment. This issue has been resolved. Claims may be resubmitted.

• **April 14, 2009 -** Attention Practioners, in the event a PACE number is obtained for an elective admission, the number must be reported in Item 23 of the CMS 1500 form. If authorization has also been granted by the Office of Medical Affairs for the same admission, the PA number noted in the letter must be entered in the remarks section of your claim.

• **April 7, 2009 -** The MDCH would like to inform Outpatient hospital providers that systems changes to implement January 2009 OPPS/APC updates has been completed. Claims with January 2009 dates of service have been adjusted and will appear on the remittance advice dated 4/8/09, pay cycle 14. When claims with February 2009 dates of service are adjusted you will be notified.

• **April 7, 2009 -** Please be advised that providers are receiving 841 and 860 rejections on inpatient claims when they bill with a primary diagnosis code that went into effect 10/1/08. Our system has an error in the logic that is not able to group the claim to price. These rejected claims are for dates of service with admission date of 10/1/08 - 12/31/08. Once this has been fixed a notification will be sent out.

• **April 2, 2009 -** Due to systems issues, the March Medicare reports, dated March 24, 2009, from TPL were sent out in error. Please disregard. We apologize for any inconvenience this may have caused.

• **March 23, 2009 -** Due to the many concerns, Third Party Liability has removed all potential claim adjustments for providers: Home Health Agency, Hospice, Private Duty Agency, Family Planning, Local Health Departments, Federally Qualified Health Centers, Tribal Health Centers and Rural Health Centers from our pending claim adjustment process. Providers will be notified of any attempt to restart this process for these providers prior to implementation. We apologize for any inconvenience we unintentionally caused with our new process.

• **March 19, 2009 -** Attention Outpatient Hospital Providers: MDCH would like to

inform Outpatient providers that the Jan 2009 APC updates have been completed. The MDCH will initiate claim adjustments for any Outpatient claims with 2009 dates of service that have paid incorrectly.

• **March 17, 2009 -** The following counties have been added to the Michigan Department of Community Health's Bridges program: Allegan, Berrien, Cass, Clinton, Gratiot, Ionia, Jackson, Kalamazoo, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa, St Joseph and Van Buren County.

• **February 20, 2009 -** Please be advised, the MDCH has added Patient Discharge Status Code 70, used to report discharges or transfers to other types of health care institutions not defined elsewhere in the National Uniform Billing Committee manual.

• **February 18, 2009 -** Attention Outpatient Hospital Providers: MDCH would like to inform Outpatient providers that the Jan 2009 APC updates have not yet been completed. The MDCH will initiate claim adjustments for any Outpatient claims with 2009 dates of service that have paid incorrectly once the implementation of the APC updates are completed.

• **February 17, 2009 -** Ingham County has now been added to the Michigan Department of Human Services (DHS) Bridges program.

• **February 17, 2009 -** Institutional providers billing for CPT code 90378 may have received the 099P 727R in error. The problem has been corrected and MDCH will recycle the claims that were rejected in error.

• **February 6, 2009 -** Providers billing 36415 may encounter erroneous rejections. The error has been identified and corrected. Claims rejected with 761R, 099P and 104P may be resubmitted at this time.

• **January 28, 2009 -**In August, 2008, the Michigan Department of Human Services (DHS) kicked off its first pilot County for the Bridges program in Calhoun County. On 1/19/2009 Eaton and Barry counties were added to the Bridges program. Bridges is Department of Human Services' new eligibility and case management system. This on-line system will utilize beneficiary income and assets to determine all assistance programs the beneficiary is eligible for including medical assistance, food assistance, cash assistance and more.

• **January 26, 2009 -**The 841 edit is setting erroneously on inpatient claims. As a result, claims are rejecting in error. A systems correction is required for the claims to process correctly. Providers will be notified when the correction is implemented.

• **January 21, 2009 - Please be advised**, providers who submitted claims electronically and received an acknowledgment that their claims submitted on 1/5/09 were accepted; there was a system error which caused the claims to be dropped. The MDCH will internally submit the claims and providers can expect to see them on pay cycle 4 dated 1/28/09.

• **January 5, 2009 - Please be advised:** Pay cycle 52 will be issued on 12/23/2008 and will be the last pay date of the year. There will be no pay cycle dated 12/31/2008. The next pay cycle will be Pay cycle 1 which will include both the 12/31/2008 and 1/7/2009 pay cycles. (Originally posted 10/13/08)

• **December 5, 2008 -** The 835 (electronic remittance advice file) for Pay Cycle 48 (November 26, 2008) was sent to Billing Agents with incomplete or incorrect warrant information. This file was reprocessed and resent to all Billing Agents on Pay Cycle 49 (December 4, 2008). Please disregard the original 835 file sent for Pay Cycle 48 on

November 26, 2008.

• **December 5, 2008 -** Updated March 6, 2009: Currently MDCH is processing all paper claim types with Julian date 9009 (January 9, 2009).

• **October 29, 2008 -** In August, 2008, the Michigan Department of Human Services (DHS) kicked off its first pilot County for the Bridges program in Calhoun County. Bridges is Department of Human Services' new eligibility and case management system. This on-line system will utilize beneficiary income and assets to determine all assistance programs the beneficiary is eligible for including medical assistance, food assistance, cash assistance and more. The beneficiary ID will change from 8 digits to a 10 digits, refer to MSA Bulletins 07-59 and 07-54. New mihealth cards will not be issued to current beneficiaries; therefore beneficiaries may present an 8 or 10 digit mihealth card. The mihealth card issued to a new beneficiary will contain 10 digits leading with numeral 1. If the beneficiary presents an 8 digit card, the provider should enter the ID on the claim with two leading zeros. The mihealth card is not an indicator of eligibility; the provider should always check beneficiary eligibility through the Eligibility Verification System (EVS) prior to providing services. In addition to the beneficiary ID, the case number will change from an alpha-numeric to all numeric 9 digit case. The Department of Human Services anticipates full implementation of Bridges to all counties within the next six months. For updates on Bridges please continue to check this website.

• **October 13, 2008 - Please be advised:** Pay cycle 52 will be issued on 12/23/2008 and will be the last pay date of the year. There will be no pay cycle dated 12/31/2008. The next pay cycle will be Pay cycle 1 which will include both the 12/31/2008 and 1/7/2009 pay cycles. (Revised 10/14/08)

• **October 8, 2008 - Update (10/16/08): The registration for this billing session is now closed.** A Long Term Care Billing Session will be held on 10/30/08, at the Lewis Cass Building 320 S Walnut Lansing MI 48909. This session will consist of a one hour power point presentation with a questions and answer session following. If necessary, a problem focused session will be available following the presentation and questions. Space is limited, please e-mail providerconsultant@michigan.govfor confirmation. Please include your NPI number, how many wish to attend, a contact number phone number, and if you are requesting time for a problem focused session.

• **October 2, 2008 -** The Michigan Department of Community Health (MDCH) would like to clarify existing policy and provide additional information regarding the reporting requirements for present on admission (POA) indicators. Effective October 1, 2008, Medicare and Blue Cross Blue Shield of Michigan (BCBSM) will be implementing policies to not pay a higher diagnosis-related group (DRG) [inpatient hospital] payment for specific Hospital Acquired Conditions (HACs) considered not POA. MDCH will keep with current policy published in the Coordination of Benefits (COB) Chapter (refer to Section 2 and 2.6) of the Michigan Medicaid Provider Manual in following the rules of the primary payer. For hospital discharges on and after October 1, 2008, providers must follow the POA reporting requirements for Medicare and Blue Cross Blue Shield of Michigan on secondary claims to Medicaid, also requiring providers to report the prior payers DRG appropriately when submitting secondary claims to Medicaid for reimbursement. MDCH will pend for review all secondary inpatient claims for possible HAC's and payment assignment by the primary payer. This is not a requirement for providers submitting primary claims to Medicaid. MDCH does not require POA

indicators on Medicaid primary claims at this time.

• **October 2, 2008 -** CHAMPS revalidation has been very successful and we want to thank all the providers that have accessed the system and completed their revalidation. If you have begun your revalidation, please complete it as soon as possible. MDCH will now begin disenrollment activities which will be completed by the end of October for those who have not revalidated in CHAMPS.

• **September 15, 2008 -** On September 25, 2008 - MDCH is offering Provider Consultant Sessions, for new professional providers. The session will be located at the Lewis Cass Bldg, 320 S. Walnut St, Lansing, MI. Please e-mail your Medicaid Provider NPI#, Contact Name and Phone Number to providerconsultant@michigan.gov to reserve your place, seating is limited. A consultant will contact you for confirmation.

• **September 4, 2008 -** Attention Practitioner Providers: Providers may now submit claims with modifiers UA and UD directly to Medicare. Claims should process correctly and automatically crossover to Michigan Medicaid. Medicare will no longer deny due to the use of the UA and UD modifiers.

• **August 14, 2008 -** Effective immediately, MDCH will grant providers a one month extension (through September 30, 2008) to access the CHAMPS PE online system and enter their required revalidation information. Providers who have not revalidated prior to October 1, 2008 will be end-dated in the CHAMPS PE system, resulting in the rejection of any service provided on or after that date. Please reference MSA Bulletin 08-33 .

• **July 24, 2008 -** Attention Outpatient Providers: MDCH has resolved the OPH systems error which caused incorrect adjudication off of the Revenue code. All OPH claims from Pay Cycle 27, 28 & some claims from Pay Cycle 29 with this adjudication error have been identified and will be adjusted starting on Pay Cycle 31 (7/30/08) and continuing through Pay Cycle 33.

• **July 21, 2008 -** Because of MDCH's continued commitment to bring the current 30 plus year old processing system into the 21st century, building CHAMPS has become a primary focus for the department. This project involves many staff members who are working to create a better, more user friendly system. This means (and will continue to mean) that current system issues cannot be corrected in the old system while building a new one. In this transitional period until claims goes live in the new system, MDCH providers have several valid concerns about payment when their claim is billed correctly and the system cannot adjudicate for payment. Therefore, if Provider Inquiry (PI) hotline staff review your claim issue and determine it to be a valid system malfunction, the issue may be referred (after PI's determination) to a Provider Consultant for them to consider the means appropriate to have your claim adjudicated. If, however, lack of correct billing guidelines on the part of the provider is the issue, correction according to those guidelines and resubmission of the claim will be the responsibility of the provider. Only if this is determined to be a system issue by Provider Inquiry will a claim be escalated to a consultant. Thank you for your continued patience as MDCH works diligently to bring you a processing system that will allow direct claims entry, the means to track the status of your claims, and online correction to pending or rejected claims. You will also be able to track your payments online. These are the goals of our department to help build a better working relationship, involving claims processing and submission, with our providers.

• **July 3, 2008** – **Attention Outpatient Hospitals**: MDCH implemented a systems

change for Outpatient claims processed on/after Pay Cycle 27 which has caused an error in adjudication of all OPH claims. While some claims may have priced correctly off of the Procedure code, the adjudication error off of the Revenue code has caused additional rejections for edit 552 (Duplicate claim/line) and also caused the Revenue codes to display on all claim lines on the Remittance Advice. MDCH will be generating claim adjustments for all outpatient claims affected by this issue once the systems error has been corrected.

• **July 2, 2008** - **Attention Private Duty Nursing**: MDCH is reminding PDN staff to clock out at 11:59 p.m. and back in at midnight if they are working an overnight holiday shift. Doing so will avoid corrections for holiday pay.

• **June 26, 2008** – Effective pay date 10/01/2007 or after, services billed properly for Family Planning using a FAO Group Billing NPI number (type 2) and a Rendering Health Officer NPI number (type 1) will be paid at the proper 90% reimbursement during time of settlement if a Family Planning diagnosis was on the claim. Many Health Departments may notice that office visits for these services may crosswalk and pay based on the legacy provider type 77 Health Officer number. Just remember to use the correct Family Planning diagnosis code, correct billing NPI, and rendering NPI numbers for these services to ensure proper reimbursement.

• **June 13, 2008** – CMS approved a six-month extension for reporting NDCs through 6-30-08. MDCH recently worked with the Michigan Hospital Association (MHA) for another extension on behalf of Medicaid enrolled OPHs, however, CMS has formally denied this request. MDCH will implement the NDC policy reporting requirement per MSA 08-02. Effective for dates of service (DOS) on and after July 1, 2008, Outpatient Hospital Providers (OPHs) are required to report the National Drug Code (NDC) for physician administered drugs as described in MSA policy bulletins 08-02 (prior MSA 07-33, 07-61) and Section 6.12 Billing & Reimbursement for Institutional Providers of the Manual. Providers are not required to report packaged/bundled Medicare Status Indicator (SI/N) NDCs. Edit 955 will set at the claim line level if the NDC is not reported appropriately. Providers are referred to the CMS link for the non inclusive list of NDCs at: http://www.cms.gov/McrPartBDrugAvgSalesPrice. We suggest you check this site often. 340B hospitals are required to billactual acquisition cost of a drug if purchased at the 340B price per federal law as part of their participation in the 340B Program. Providers must report the appropriate NDC, and MDCH may recoup payment(s) for billings in violation of this policy.

• **June 6, 2008** – **Attention Private Duty Nursing- Provider Types 10 and 15**: MDCH has identified duplicate payments for Private Duty Nursing providers. Claims will be taken back in the near future.

• **March 27, 2008** – MDCH would like to inform Outpatient (PT40) providers that systems changes to implement January 2008 OPPS/APC updates have been completed effective pay cycle 11 date 03/12/08. The MDCH will initiate claim adjustments for any Outpatient claims with 2008 dates of service that have paid prior to pay cycle 11. Claims with 2008 dates of service that have been rejected with the 841 edit will also be resubmitted. The first batch of adjustments will be for claims with January 1st-15th dates of service and should appear on the

remittance advice dated 4/3/08, pay cycle 14. The remainder of claims to be adjusted should appear on the remittance advice dated 4/10/08, pay cycle 15.

• **March 25, 2008** – August 2006, NUBC restricted the use of value codes for reporting deductible/co-insurance/co-pay amounts (A1, A2, A7, B1, B2 & B7, C1, C2 & C7) to paper claims only. This change was implemented by Medicare for claims with dates of service on/after July 1,2007. MDCH will be implementing this change for Inpatient and Outpatient Hospitals institutional claims on May 1, 2008. Providers must report deductible/co-insurance/co-pay amounts using CAS codes, rather than value codes, for all Michigan Fee-For-Service Medicaid electronic inpatient and outpatient claims with date of service July 1, 2007 and after. All claims with dates of service prior to July 1, 2007 must be reported with value codes. In April, MDCH will set edit 415 informational on all electronic IPH/OPH claims that do not contain CAS segments for co-ins/ded/copays. **Starting in May, MDCH will begin rejecting electronic claims with dates of service on or after July 1, 2007 that have Value Codes only reported.**

• **March 21, 2008** – **Attention Public Health Agencies**: The Michigan Department of Community Health (MDCH) again offers its many apologies for the persisting billing issues affecting MIHP Providers, Family Planning Clinics, and Public Health Agencies. The Department realizes that this is beyond an inconvenience to your organizations. A dedicated group of MDCH staff continue to work diligently and consistently to unravel the confounding relationships between old edit logic and newer NPI crosswalk logic causing these problems. The latest strategy, involving re-enrolling all affected providers that we are able to identify, is still being tested. Other updates to claims editing logic will be tested this week. Currently, Vision, Hearing and Dental claims are adjudicating properly. Vision, Hearing, and Dental claims should report both a Billing and Rendering NPI. MIHP Provider and Family Planning Clinic claims are not adjudicating properly due to issues with the Rendering NPI. A separate test to fix this issue will be complete late next week. It is very important that MIHP and Family Planning claims have both a Billing and a Rendering NPI for annual reporting and program integrity therefore these claims must not be submitted until this issue has been resolved. Immunization and Blood Lead procedures are currently experiencing NPI issues at both the Billing and Rendering NPI levels. NPI issues with MIHP, Family Planning, Immunizations, and Blood Lead procedures are occurring regardless of single or multiple enumeration. MDCH would also like to make it clear that claims affected by these NPI issues are exempt from the 12 month billing limitation. Until CHAMPS is available for claims adjudication, Public Health claims affected by NPI implementation can be submitted for dates of service up to 2 years old. This will ensure that we can all still benefit from proper data collection for both payment and reporting purposes. MDCH is also aware of several NPI transmission issues with claims received from Netwerkes. The Department is working with Netwerkes to resolve these issues. LHDs requesting advance payment for Fee For Service claims should email providersupport@michigan.gov with "LHD Advance" in the subject heading and the NPI, the dollar amount requested, a brief explanation of what the dollar amount represents and why an advance is being requested,

provider/LHD/Director name, contact person, and phone number. Advance payments are not considered payment for services rendered. Advance payments would appear as a gross adjustment on a remittance advice as a lump sum to be recovered by a negative gross adjustment later and reconciled by proper claim adjudication when the system is fixed. It has been a very unique struggle to transition these Public Health providers' enrollments from a single, combination-rendering/billing ID claim edit method to a two-NPI per claim edit method. We appreciate the hard work and patience of you and your staff to help us resolve this issue as quickly and effectively as possible.

• **December 5, 2007** - Due to a systems error, Hospital outpatient APC void claims (DOS on/after 4/1/07) were not correctly taking money back for pay cycles 18-37. The claims were actually being approved again and the original money was not being recovered. In some instances, the void claims even paid more/less than the original paid claim. Due to the nature of the systems error and the fact that the claim is now voided from the paid claims history file, this does not allow for any internal nor provider related adjustments. MDCH will create gross adjustments to recoup the monies from the affected claims and a letter will be sent to providers detailing which CRNs were included in the gross adjustments related to this issue.

• **November 26, 2007** - Family Planning Clinics (provider type 23) may rebill any previous 639 rejections after October 1st. Submit the claim as follows "bill to field" (Loop 2010AA electronically) must be the Health Department group NPI number and the "rendering field" (Loop 2310B electronically) must be the physician type 77 NPI number. Use the Health officer that was designated for MIHP/FP services.

• **November 6, 2007** - MDCH has identified issues with the NPI reporting back incorrectly on the 835 (Electronic Remittance Advice) for pay cycles 41-45. Beginning November 14th, pay cycle 46, the 835 should be reporting back the correct NPI number in the TS3 segment of the 835. For more information on what is expected to be returned in the 835 file, please view the 835/277U Companion Guide located on our website at www.michigan.gov/medicaidproviders >>Electronic Billing. If you have any questions on this issue please contact AutomatedBilling@michigan.gov .

• **October 23, 2007** - MDCH has identified NPI issues for Pay Cycle 40, 41 and 42. MDCH has resolved all internal issues and providers may resubmit all claims that rejected in error for NPI issues. Providers may be experiencing edits 634, 635, 636 and 639 on their RAs. These are valid edits that will set if an NPI is missing or invalid, or if an invalid zip code is reported. If you have a valid NPI and you are still receiving the edits above, make sure that your NPI has been reported to MDCH through our Single Sign-On (SSO) application. If you have not reported your NPI to MDCH, please find instructions at the NPI website at www.michigan.gov/mdch>> Providers>> NPI.

• **October 22, 2007** -MDCH has identified NPI issues for Nursing Facility providers where edit 682 was setting in error. The issue has been resolved, MDCH apologizes for any inconvenience this may have caused. Nursing Facilities may now resubmit claims that set edit 682 in error.

• **October 16, 2007** - Providers need to resubmit their claims if they received rejection 639 or 239 in error. Remember to submit the NPI, the tax number in the billing loop, and the correct zip code to avoid rejections. Refer to MSA 06-73 & MSA 07-48.
• **September 27, 2007** - Outpatient Hospital claims within Pay Date September 12, 2007 and September 19, 2007, MDCH edit 092 set in error for certain claim lines that were billed with status indicator "N" (revenue codes that HCPC codes are not required, i.e. 250, 260, 272, 370, 371, and 372) under Provider Types 40. Medicaid has resolved this issue. Providers can submit replacement claim if entire claim did not reject.
• **September 27, 2007** - Effective pay cycle 40, October 3, 2007, provider warrants will be issued on Thursdays. This is a change from the current practice of issuing warrants on Wednesday. The change will not affect provider payments issued via Electronic Funds Transfer (EFT), which will continue to be processed on Thursdays. EFT is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. Providers interested in initiating an EFT may do so through to the Department of Management and Budget website at www.cpexpress.state.mi.us .
• **September 19, 2007** - In August 2006, NUBC restricted the use of value codes for reporting deductible/co-insurance/co-pay (A1, A2, A7, B1, B2 & B7, C1, C2 & C7) to paper claims only. This change was recently implemented by Medicare for claims with dates of service on/after July 1, 2007. MDCH will be implementing this change for Inpatient (PT 30) and Outpatient (PT 40) Hospitals and will be completing our system testing over the next several weeks. In the interim, providers should continue to submit value codes along with the appropriate CAS segments and reason codes on any secondary claims to MDCH until these system changes have been made. We will provide further information regarding the effective date of this change on our Provider Biller B'Aware website and through the Provider ListServ in the near future.
• **September 18, 2007** - MDCH has identified an issue with paper CMS 1500 claims paying secondary claims incorrectly. MDCH is working on this issue and will resubmit the incorrectly processed claims when it has been resolved. Providers should fill out fields 11a-d when submitting Primary coverage on the CMS 1500.
• **August 1, 2007** - MDCH is offering Provider Consultant Sessions for all providers. The next session is scheduled for August 16 at the Lewis Cass Bldg, 320 S. Walnut St, Lansing, MI. Please set up an appointment by emailing ProviderSupport@michigan.govincluding your Medicaid Provider ID and Type, Contact Name and Phone Number. A consultant will contact you for an appointment time.
• **July 25, 2007** -MDCH is offering Business to Business (B2B) Testing for claims with NPI only to all Trading Partners. MDCH encourages the submission of test files with NPI only to guarantee claims will adjudicate correctly and that all Billing Agents will be able to receive and download the 835 (Electronic RA) file properly. Due to changes with Group NPI and Individual NPI, providers should encourage their Billing Agents to submit test files on their behalf. MDCH will also be taking

any suggestions at this time for changes to the 835 file. MDCH will be mandating the use of NPI only on October 1, 2007.

• **July 19, 2007** - MDCH has identified dental claims (provider types 12 and 74) for procedure codes paid incorrectly in 2006 and 2007. The codes affected are D0210, D0272, D0274, D1110, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2710, D7140, D7210, D7220, D7230, D7240, D7250. Claim adjustments will be submitted by MDCH in the near future.

• **July 2, 2007** - MDCH has identified that some primary inpatient hospital (provider type 30) claims were processed and paid at $0 for part of pay cycle 27, July 3, and pay cycle 28, July 11. Inpatient hospital claims secondary to Medicare or other insurance were processed and paid correctly. MDCH will resubmit claim adjustments for these claims as soon as possible.

• **July 2, 2007** - MDCH has identified an error which caused some institutional claims in pay cycle 27, July 3, to reject or pay incorrectly. MDCH is in the process of resubmitting these claims and will process them as soon as possible.

• **June 29, 2007** - Beginning July 1, all providers can submit Business to Business (B2B) test files with the NPI only to MDCH.

• **June 25, 2007** - The FD-622 reports have not been printed for the payrolls of June 6,13, and 20th due to a printer set up problem. This has been resolved and the reports will be rerun and should be completed by June 27.

• **June 22, 2007** - The Michigan Medicaid Training Sessions for the new CHAMPS Provider Enrollment Subsystem are posted online at www.michigan.gov/medicaidproviders>> Medicaid Provider Training Sessions. MDCH recommends that representatives from every Provider's office register for a session. **It is beneficial to have Provider Enrollment staff attend, along with Credentialing and Billing staff.** All sessions will include an overview of the CHAMPS system with emphasis on the Provider Enrollment subsystem. A preview of the Provider Enrollment screens will be available along with information on the revalidation process and the information that all Providers will need to revalidate and enroll with CHAMPS. You don't want to miss it...Sign up today!!!!

• **June 7, 2007** - MDCH has identified the following issues: 1) Overpayments on nursing facility claims that involve HMO Medicare Co-Insurance Days; 2) Claims that paid incorrectly in 2006 and 2007 for procedure code D7210 for Provider Types 12 and 74, and 3) Incorrect reimbursement for the MS modifier on procedure codes E0193 and E0194, which has been corrected as of June 4, 2007. All claims will be adjusted in the near future by MDCH.

• **May 8, 2007** - The April Medicare OPPS updates have been incorporated into the MDCH OPPS effective for Pay Cycle 19. MDCH will review OPPS claims processed prior to implementation of the April updates and re-adjudicate any claims that are identified with material variances as a result of the updates. A revised OPPS Wrap Around list is now available on the MDCH website. The list has been updated with additional codes considered as MDCH Status R1 Non-covered items under OPPS.

• **May 8, 2007** - When Nursing Facility and Hospice providers receive payment for the same beneficiary on the same date of service, voided claims will be submitted by MDCH, these are identified as duplicate room and board claims.
• **May 8, 2007** - Claims paid for Private Duty Nursing Providers, Provider Type 10 and 15, for date of service, January 1, 2007 will be submitted by MDCH in the near future as replacement claims allowing the Holiday rate to be paid.
• **April 30, 2007** - Correction has been made as of April 30, 2007 to the radiology procedure codes that are approving zero dollar amounts when billing the modifier 26. Claim adjustments will be submitted by MDCH in the near future.
• **April 13, 2007** - An electronic health care claim payment/advice (ASCX12N 835 4010A1) is sent to a designated primary billing agent per Federal Tax ID for providers choosing an electronic RA. For those providers receiving an electronic RA (835), if you do not wish to receive the paper RA submit a request via e-mail to MDCH, Provider Enrollment Unit at ProviderEnrollment@Michigan.gov . The request must include the Medicaid Provider Billing ID number and Federal Tax ID. The correction will be made per individual Billing ID.
• **April 13, 2007** - To avoid unnecessary claims rejection or incorrect payment, all institutional claims (both electronic and paper) must submit claims with valid type of bill (TOB). Valid type of bills are below. All institutional claims reporting with invalid type of bill (TOB) codes will be denied for payment. For paper claims form, the four-digit TOB code is to be reported with a leading zero in Form Locator 04. **It is going to be essential to cross walking back to the correct billing ID with NPI implementation.**
- Inpatient hospital (PT 30) includes: 11X, 12X, or 41X
- Outpatient hospital (PT 40) includes: 13X, 14X, 34X, 72X, 74X, 75X, or 85X.
- Nursing facility (60, 61, 62, 63, 64, 70, 71, or 72) includes: 18X, 21X, 22X, 23X, OR 28X
- Hospice (PT 15) includes: 81X, or 82X
- Home health (PT15) includes: 32x, 33x, or 43X
- ICFMR/Inpatient (PT 65) includes 65X, 66X

• **April 10, 2007** - On May 23, 2007 the Provider Consultants will be holding a Help Session for Hospitals, Physicians, Dentist, Special Services and Nursing Homes in conference room F in the lower level of the Capitol Commons Center in Lansing. To register please send an e-mail to Providersupport@michigan.gov , a Consultant will contact you with a appointment time. Availability will be on a first come, first serve basis.
• **April 5, 2007** - The Michigan Department of Community Health (MDCH) Outpatient Prospective Patient Payment System (OPPS) implemented April 1, 2007 for MDCH enrolled Provider Type 40 providers. Until MDCH is able to incorporate the recently received Medicare OPPS changes for April, claims for dates of service on and after April 1, 2007 will be processed utilizing Medicare's January 2007 OPPS and applicable fee schedules. Once the April updates are complete, MDCH will review claims paid and re-adjudicate any claims that are identified to have material variances. Providers are asked to contact Provider Support at providersupport@michigan.gov or 1-800-292-2550 with any questions or concerns.

• **April 2, 2007** - For Pay Cycles 13 and 14 (Pay Dates 3/28/07 and 4/4/07), MDCH Edit 817 – OPH Group Reimbursement did not set for claims that were billed by Provider Type 40 which resulted in overpayments to providers for outpatient services. This error has been resolved effective for Pay Cycle 15. MDCH will be identifying claims that were paid incorrectly and generating claim adjustments to correct the overpayments in the near future.
• **March 22, 2007** - Michigan Department of Community Health (MDCH) is delaying acceptance of the CMS 1500 (08/05) paper claim form until June 1, 2007. Policy Bulletin MSA 07-18, with a targeted release date of March 28, 2007, alerts providers of this change. The bulletin will be sent to all providers currently billing on the CMS 1500/837 professional claim format. Policy Bulletin MSA 07-09 had previously announced MDCH would require paper claims for professional services be submitted using the CMS 1500 (08/05) effective April 1, 2007. Any CMS 1500 (08/05) claims forms submitted prior to June 1, 2007 will be returned to the provider.
• **March 12, 2007** - Other insurance Explanation of Benefits (EOBs) are only needed for paper secondary claims. Providers submitted secondary claims electronically do NOT need to submit an EOB. MDCH encourages all providers to submit claims electronically, especially secondary claims.
• **February 8, 2007** - New Training Sessions are posted at the Provider Training Session website. Please visit www.michigan.gov/medicaidproviders >> Medicaid Provider Training Sessions. The online registration form was experiencing system errors last week. If you signed up for any sessions during that time, please resubmit your registration form now. If you have not received a confirmation, please email ProviderOutreach@michigan.gov.
• **January 26, 2007** - Section 10.2.A of the Medicaid Nursing Facility Coverage policy states: "Medicaid reimburses a nursing facility to hold a bed for up to ten days during a beneficiary's temporary absence from the facility due to admission to the hospital for emergency medical treatment only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. "On the day" is defined as the facility's census at midnight (i.e., 12:01 a.m.) on the day that the beneficiary leaves. Note that calculation of available bed occupancy for purposes of Medicaid reimbursement for hospital leave days is different than calculation of occupancy for cost reporting purposes." Medicaid needs to reiterate what is meant by 12:01. The 12:01 simply means a new day. That is, what is the census at midnight 12:00 a.m. or when the activity begins for the new day at the facility. If no new census was done at the start of the new day then your midnight census would be calculated using the census at the end of the day from the night before or 11:59 p.m. census.
• **January 10, 2007** - Less than 5 months until the NPI mandate of May 23, 2007. Please make sure to view our NPI website today! The link for the NPI website is located at the bottom of this webpage. If you have any NPI questions please contact Provider Inquiry at 1-800-292-2550 or email npi@michigan.gov.
• **January 5, 2007** - MI AuthentiCare will not be available on 1/6/2007 from 8:00 AM to 11:00 AM EST for an upgrade to the power system. PDN Providers will need to submit Record Correction Forms for services provided during this time

period. Adult Foster Care Providers should not use MI AuthentiCare during this time period. We apologize for any inconvenience this may cause you.

• **January 4, 2007** - MDCH should be receiving the 2007 OPPS updates/changes from our software vendor in the next two weeks and in order to make one single update to our system and provide the most current pricing and editing results to providers, MDCH will be holding any OPPS B2B submitted test files and delaying the OPPS Pilot Project until mid to late January. Once the 2007 OPPS updates are complete and migrated over to the OPPS B2B test system, we will re-run all submitted OPPS B2B test files through the OPPS B2B and notify the providers that these files have been resubmitted. We will also notify the Pilot hospitals that they can begin submitting their shadow billed OPPS test files at that time.

• **December 21, 2006** - MDCH is currently finalizing the specs to implement the new CMS 1500 (08/05) claim form with an implementation date planned for April 1, 2007. A bulletin with a proposed release date of February 1, 2007, will be published to providers with special claim completion instructions specific to meet the claim processing needs for MDCH in addition to following the NUCC instructions.

• **December 21, 2006** - Michigan Department of Community Health has identified beneficiary co payments for medical services are being taken out of Federally Qualified Health Centers (FQHC) and/or Rural Health Clinics (RHC) claims in error. The claims will be identified and adjusted by MDCH once the system is corrected.

• **December 4, 2006** - Effective October 1, 2006 dates of service, Bulletin MSA 06-61 changed the MSA code to using the CBSA (Core Based Statistical Area wage index) in the value code area of Hospice claims. The new code that they are to use changed from a 4 digit code to a 5 digit code. They are published on our website under the fee screen for Hospice Providers 2007. The bulletin was sent to Nursing Homes but was not sent to Hospice providers that utilize this code on their billing.

• **December 4, 2006** - For all Home Health, provider type 15, providers, MDCH has identified claims that were overpaid on procedure code G0154 during 2005 payment dates. The recoveries will be completed within the next few weeks.

• **November 8, 2006** - As a result of the State Holiday Tuesday, November 7th payroll will be one day late. Warrants will be dated November 9th and EFT payments will have a November 13th settlement date.

• **October 6, 2006** - When providing services for newborns, it is very important to verify the type of coverage that the mother has at the time of birth. If the mother is in a Medicaid HMO, the newborn will be automatically enrolled retro to birthdate in the same HMO. There may be a period of time that the HMO information is not reflected on the eligibility file, however it will be added retroactively and any payments made will be recovered quarterly.

• **October 2, 2006** - The latest batch of MDCH Quarterly Newborn Recoveries was completed in PC39 (9/27/06). This batch included fee for service claims for newborns who were retroactively enrolled into a health plan with dates of service on or after 10/1/04 paid through 6/30/2006. Note: This quarterly batch is larger than previous batches as MDCH did not do a quarterly recovery for claims paid

through 3/31/2006 due to issues with eligibility information at that time. If you have questions regarding specific claims or need assistance, please contact MDCH Provider Inquiry at (800) 292-2550 or via e-mail at ProviderSupport@michigan.gov.

• **September 22, 2006** - When submitting any type of documentation with a paper claim, do not use highlighter on the attachment. The highlighted area appears as blanked out information when the claim and attachment are scanned into the claims processing system and it cannot be read which may result in a rejection.

• **August 1, 2006** - This is a reminder that B2B testing for MDCH's Outpatient Prospective payment System (OPPS) is scheduled to begin on August 1, 2006. Updated B2B instructions and other OPPS information are available on the MDCH website at www.michigan.gov/medicaidproviders >> Outpatient Prospective Payment System (OPPS) Project.

• **July 13, 2006** - Effective on Pay Cycle 19, per MSA Bulletin 06-17, MDCH implemented a Beneficiary Co-Payment policy for certain services for claims with dates of service on or after May 1, 2006. There have been two issues identified with claims adjudication for these copayments and they have been corrected as of Pay Cycle 25. 1) Co-payments were not being deducted for claims with services for procedure codes 99211-99215. 2) Co-payments were being deducted for Medicare secondary claims when they should not have been. MDCH will be identifying these claims that were paid incorrectly and generating claim adjustments to correct both of these issues in the near future.

• **June 21, 2006** - Duplicate claims for Hospice Room and Board have been identified for Pay Cycles within 2003 through March 2005. These duplicate claims will be automatically taken back, providers will see these take backs on your Remittance Advices with the next few Pay Cycles.

• **May 23, 2006** - Beginning on Pay Cycle 20, MDCH is implementing a new edit that will notify providers if an invalid Type of Bill was submitted on an outpatient claim. Valid Type of Bills for Outpatient Hospitals include: 13x, 14x, 34x, 72x, 74x, 75x or 85x. Edit 638 - "Invalid Type of Bill" will be informational only at this time and will not reject your claim.

• **May 23, 2006** - Effective on Pay Cycle 19, per MSA Bulletin 06-17, MDCH implemented the Beneficiary Co-Payment policy. For dates of service May 1, 2006 or greater when a co – payment has been taken, your RA will reflect Edit 088 -“The co payment has been deducted.”

• **May 19, 2006** - Medical supply code A4554 (Disposable Underpads) was eliminated from Medicaid coverage for dates of service on and after December 31, 2004. Replacing A4554 are T4541 (Disposable Underpads/large) and T4542 (Disposable Underpads/small). The provider specific information data base for home health agencies will be updated.

• **May 11, 2006** - There is a new shortcut to get to the Information for Medicaid Providers web page. Anyone that would like to go directly to that page may click on www.michigan.gov/medicaidproviders.

• **May 11, 2006** - Please review the L-Letter L-06-12, for clarification on Medicaid policy for beneficiary pharmacy insurance, deductible, coinsurance, co-pays, and premiums.

• **April 14, 2006** - Medicaid has posted a PowerPoint for all out of state providers. Out of state providers may find this PowerPoint in the "Provider Tips" section below.
• **April 14, 2006** - Medicaid inpatient hospitals should be receiving the new FD622 report and the old FD622 report. The new report has additional information that has been added from direct requests from the hospitals. Please review the parallel reports and provide feedback to Medicaid for any additional comments or changes. Medicaid will soon have available the FD622 for the outpatient hospitals.
• **April 13, 2006** - July 1, 2006, MDCH will implement a new waiver for family planning services to women of childbearing age 19-44 years of age called Plan First! Plan First! will allow women who are not currently Medicaid eligible, do not have full family planning benefits through private insurance, including Medicare, or who have family income at or below 185 percent of the FPL to receive family planning services. Coverage would be limited to women who reside in Michigan and meet Medicaid citizenship requirements. For more information please view the Plan First! Waiver.
• **April 13, 2006** - In a previous posting, dated January 12, 2006, MDCH notified providers of claim adjustments that were incorrectly pending within the system. MDCH has resolved this issue and resubmitted the claims through the system for providers. If you feel that you have a claim that needs to be resubmitted, you may rebill at any time. For more information on the original posting, please see the Biller "B"Aware Archives below.
• **April 12, 2006** - Beginning May 1, 2006, Medicaid beneficiaries may have to pay a co-payment for certain Medicaid services, such as an office visit, emergency room visit, or hospital admission. For more provider information please refer to Medicaid Policy Bulletins web page or Bulletin MSA 06-17.
• **April 11, 2006** - For Pay Cycle 14 and 15, Pay Date 4/5/06 and 4/12/06, MDCH edit 264 set in error for certain claims that were billed under Provider Types 22, 40, 60, 61, 62,63, 65 and 73. Medicaid has resolved this issue. Providers can either wait as Medicaid will resubmit these claims for the providers on Pay Cycle 16 or providers may now rebill these claims.
• **March 29, 2006** - There is a new link posted at the MDCH website that gives specific information about the National Provider Identifier (NPI). All providers should view this site frequently. Please visit it at www.michigan.gov/mdch >> Providers >> National Provider Identifier (NPI). The link is also posted below.
• **March 22, 2006** - Medicaid is complying with a new federal initiative, Payment Error Rate Measurement (PERM) program. PERM is a result of the Federal Improper Payments Act of 2002 which directs federal agency heads to annually review programs that are susceptible to significant erroneous payments. Medicaid and the State Children's Health Insurance Program (SCHIP), referred to as MIChild, have been identified as programs at risk for significant erroneous payments. For more information, please refer to the PERM Fact Sheet and PERM PowerPoint as well as L-06-09 that was issued March 2006. If providers are contacted by the national contractor of Livanta LLC it is important that you cooperate with their requests.

• **March 22, 2006 -** Private Duty Nursing Bulletin MSA 06-06 and the April 2006 online Medicaid Provider Manual Directory Appendix gives the fax number (517) 241-0743 as the number to fax initial and continued authorization requests for private duty nursing. Do not use this fax number. Please fax initial and continued authorization requests to: (517) 241-7813.
• **January 12, 2006** - Claim adjustments received on and after 1/1/06 may be pending 158 inappropriately. The system is reading the original CRN incorrectly. Claim replacements are also rejecting 552 in error. In addition, the system is reading Prior Authorization numbers incorrectly causing some claims to reject 015 in error. Providers will be notified via Provider Updates and the Medicaid ListServ once these issues have been resolved.
• **March 2, 2006** - Ambulance claims may have been paid incorrectly that were processed from November 2005 through January 2006 using modifier 22. Modifier 22 was not properly acknowledged on multiple transport claims resulting in payments for one trip. Providers that had claims that were paid incorrectly must file replacement claims to receive reimbursement for multiple trips.
• **February 27, 2006** - Effective 1/1/06 HCPCS code 80061 is covered at the outpatient hospital setting. Medicaid was incorrectly rejecting these claims and causing Edit 119 to set, this issue has now been resolved. Providers may resubmit any claims that have been incorrectly rejected with Edit 119.
• **February 14, 2006** - Providers must report the new universal diagnosis codes for all inpatient claims with dates of admission beginning 10/1/05 regardless of the DRG Grouper Version 22.0. Any provider that was rejected for not including the 5th digit should resubmit the claim.
• **January 17, 2006** - As of 1/1/06, pharmacies, provider type 50, will not be able to bill First Health for certain diabetic supplies. These supplies are now covered codes for DME providers. For more information please refer to the Diabetic Supplies document below within the Provider Tips section.
• **February 15, 2006** - Medicaid is trying to gather information for research about Provider contact information. MDCH is asking all providers to complete the Michigan Medicaid Provider Survey. If you have any questions on the survey, please email ProviderOutreach@michigan.gov.
• **January 20, 2006** - As of July 20, 2005, takebacks from TPL will be completed as Void/Cancel claims. If providers need to resubmit for payment, the resubmission must be a new claim. The new claim should indicate in comments the original paid CRN and PayCycle as well as the voided CRN and PayCycle. You also should indicate in the comments, "TPL Takeback - Please Repay".