Biller "B"Aware Archives

Resolved Issues

- **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)

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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.

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- **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.

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- **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.

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- **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 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".
- **December 28, 2005** - MDCH will begin using Third Party Liability (TPL) Carrier IDs to identify Medicare coverage on the Eligibility Verification System (EVS). The Carrier IDs listed below will be displayed in the TPL section of the EVS response when there is Medicare coverage on file for the date of service. The list below also gives updated Medicare Other Insurance (OI) Codes/Descriptions. Additional information provided in the EVS TPL section for Medicare (if applicable): Carrier ID/Description, OI Code/Description, Effective Dates, Medicare Part D and/or Part C Plan Policy Number, Name and Phone Number, and Contract Number (Medicare HIC).

Carrier ID	Carrier Description
11111111	Medicare - Eligible, Not Enrolled
22222222	Medicare - Eligible, Not Enrolled in Part D
33333333	Medicare - Enrolled in Part A
44444444	Medicare - Enrolled in Part B
55555555	Medicare - Enrolled in Medicare Advantage Plan
66666666	Medicare - Enrolled in Part D
77777777	Medicare - Aliens, Not Enrolled for Medicare
OI Code	**OI Code Description**
50	Alien, Medicare Excluded
90	Eligible for Medicare, Not Confirmed
91	Enrolled in Medicare (Parts A, B and/or D)
95	Enrolled or Eligible for Medicare Plus Commercial Ins.
96	Enrolled in Medicare Advantage Plan

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Resolved Issues

If the Medicare coverage indicated on EVS has terminated, or it is not being reported for the date of service, please report this information to the Medicare Buy-In Unit by phone 517-335-5488, fax 517-335-0478, or email BuyInUnit@michigan.gov. Any questions please contact Provider Inquiry at 800-292-2550 or ProviderSupport@michigan.gov.

- **December 5, 2005** - For PayCycle 47, Pay Date 11/23/2005, through PayCycle 49, Pay Date 12/07/2005, Medicare information was incorrectly rejecting and pending due to other insurance information within the Medicaid system. This issue has been resolved and claims will adjudicate correctly on PayCycle 50, PayDate 12/14/2005. Any claims, including crossover claims, that rejected on PayCycle 47 through 49 will need to be rebilled directly to Michigan Medicaid.
- **November 29, 2005** – Beginning on Pay Cycle 47, Pay Date 11-23-05, and Medicaid is incorrectly rejecting Medicare insurance as other insurance. The rejection edits you may receive are 262 or 407. Michigan Medicaid is currently looking into the situation to resolve the issue. As soon as MDCH is aware of any updates, they will be reported.
- **November 23, 2005** - Michigan Medicaid is encouraging all providers to sign up for the Michigan Medicaid ListServ. There are multiple lists that providers can request to be on, or an ALL_PROV listing where the provider will receive every email that is sent for all important updates. The ListServ instructions are posted below within the Provider Tips section.
- **November 16, 2005** - New Medicaid Provider Training Survey is now posted. Please tell us what you want from our Medicaid Training Sessions and what cities you would like us to visit. Visit the link Medicaid Provider Training Sessions or click on the link below.
- **October 7, 2005** – Effective October 1, 2005 the diagnosis code for Chronic Kidney Disease requires a fourth digit. Claims submitted with diagnosis code 585, for dates of service October 1, 2005 and after will pend 042 and subsequently reject 737.
- **September 29, 2005** - With the implementation on January 1, 2006 of Medicare Part D (prescription drugs) many beneficiaries will have questions. With the implementation of this program, Medicaid beneficiaries with Medicare coverage will have many changes to sort out. All questions about Medicare and/or Part D may be directed to Michigan Medicare/Medicaid Assistance Program (**MMAP**) at **1-800-803-7174**, web site: www.MyMMAP.org or directed to **Medicare** by calling **1-800-633-4227,** web site: www.Medicare.gov The counselors at both of these locations are trained to help all Medicare beneficiaries. If providers have Medicaid beneficiary's age 65 or older and the beneficiary has not filed for Medicare, it will be **very important** for them to do so now. If they do not have Medicare on January 1, 2006 and they are eligible (age 65 or older) prescription coverage will not be available for them. The Medicaid/Medicare Buy In unit will not be able to address questions from the beneficiaries. Please refer all questions about Medicare Part D to MMAP or Medicare counselors.
- **July 15, 2005** - As stated in the July 2005 Provider Manual Updates, Medifax has changed the way they report the Medicaid spenddown within the eligibility files. Medifax will now report this information as Medicaid deductible. The spenddown or Medicaid deductible will still be processed the same way, only the verbage has changed within the Medifax system.
- **June 24, 2005** - The State Office of the Auditor General found that DCH paid fee-for-service providers for services to newborns whose mothers were enrolled in a health plan on the delivery date and who were later retroactively enrolled in the Medicaid Health Plan (MHP).

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Resolved Issues

Beginning 07/01/05 DCH will make recoveries from providers for services for which the MHP was responsible. The initial recovery includes D.O.S. between 10/1/04 and 12/31/04 paid by Medicaid on pay cycles between 10/1/04 and 6/30/05. Subsequent recovery adjustments will be generated every 3 months thereafter.
Providers should contact the MHP for any necessary assistance. The MHPs have been notified by letter, of these recoveries and DCH has requested that they work with providers in filing claims for these services. DCH has directed the MHPs to not reject claims for newborn services from these providers for the following reasons:

- Claim filing limit has passed however, claims must be submitted to the MHP within 60 days from the Medicaid Remittance Advice Pay Date
- MHP would have required prior authorization
- MHP would have requested additional documentation

- **June 20, 2005** - On Pay Cycle 25, dated June 22, 2005 some vision claims for providers types 86 and 94 are setting with pend edit 100 in error for codes 92015, 92310, 92311, 92312, 92313, 92340, 92341, 92342, 92370, 92371 and S0592. Please do not resubmit these claims, Medicaid will post when the problem is resolved.
- **June 20, 2005 -** The death recoupment will take place on Pay Cycle 25, dated June 22, 2005.
- **June 20, 2005** - The AS modifier is now processing correctly. Providers may now submit claims.
- **June 14, 2005** - Please see the Provider Tips section below. Medicaid has now completed the ListServ process for updating providers through email about important and upcoming events. Please sign up for any ListServ which you find applicable for your organization.
- **May 26, 2005** - Please see the Medicare Crossover section below for updates on the WPS Crossover process. Currently there are problems processing claims correctly with the Medicaid payments from Medicare group providers. For more information, please see below. If you have any questions, please feel free to contact AutomatedBilling@michigan.gov.
- **May 20, 2005** - MDCH is aware that some dialysis providers have been confused with certain billing requirements that occur with Medicaid dialysis billing. MDCH has posted the document Dialysis Billing, which is listed below in Provider Tips. Please review the information for important information for dialysis billing. MDCH is currently working on claim examples and they will be posted in the near future.
- **May 16, 2005** - MDCH has identified an issue with incorrect payments for the internally generated adjustment claims on Pay Cycle 15, dated 4/13/05. This issue applies only to institutional claims where Medicaid is secondary. Once the issue has been resolved, MDCH will submit adjustments to correct the payments to the providers for these institutional claims.
- **April 21, 2005** - Due to new policy changes, Nursing Facilities have been receiving Edit 682 on the Medicaid RA since November 1, 2004. These claims should have been paid until April 1, 2005 to give the facilities a period of adjustment to the new policy. Effective April 1, 2005, Medicaid will begin rejected these claims. For any claims that have rejected due to edit 682 for dates of service **before** April 1, 2005, Medicaid is asking the provider to rebill the claim. Rejections for dates of service on or after April 1, 2005 are being adjudicated correctly and will continue to do so.
- **April 20, 2005** - The AS modifier is not currently adjudicating claims correctly when the same surgery code and Medicaid provider ID are being used. Medicaid is aware of this issue and working on the fix within the system. As soon as this issue is updated it will be posted at the website. Any questions, please contact Provider Inquiry at 1-800-292-2550.

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Resolved Issues

- **April 12, 2005** - Michigan Medicaid incorrectly adjudicated paper secondary claims that included coinsurance and deductible amounts on the same claim line for Pay Cycle 13, 14 and 15. Medicaid was currently picking up the coinsurance amount only and not including the deductible amount. Any providers that have claims that paid incorrectly for these pay cycles will need to resubmit the claims directly to Michigan Medicaid. Any questions, please contact Provider Inquiry at 1-800-292-2550.
- **April 11, 2005** - Claims that erroneously rejected with 552 on Pay Cycle 40, dated 10/6/04 will be resubmitted internally and processed on pay cycle 15, dated 4/13/05. This applies to claims where multiple lines were submitted and partial payment was made. Claims that completely rejected in error were reprocessed on October 29, 2004. The rejections were the result of a systems error, please be advised if the rejection was appropriate the resubmission will not result in payment.
- **February 28, 2005** - Any providers that submitted claims prior to January 18, 2005 and are receiving a 332 Rejection in error please resubmit these claims. The Medicaid system was not paying the date of death correctly and it caused for these claims to reject. The process is now fixed within the system. Please resubmit all rejected claims as new. For more information or questions, please contact Provider Inquiry at 1-800-292-2550.
- **February 18, 2005** - Effective immediately, please discontinue sending tertiary (paper) claims to Revenue and Reimbursement as previously instructed. The systems problem that prevented claims from processing through normal channels has been identified and corrected. Special processing of claims with Commercial insurance and Medicare with Medicaid as tertiary is no longer required. If you have questions please contact Provider Inquiry at 1-800-292-2550.
- **January 18, 2005** - Payroll for pay cycle 3, pay date January 19, 2004 is running late in the system. The paper warrants will not be issued until Monday January 24, 2005 and the EFT's will be issued on Tuesday, January 25, 2005. Pay cycle 4 is currently projected to go out on time.
- **January 13, 2005** - Private Duty Nursing (PDN) claims generated by Authenticare for pay date 12/09/2004 - 01/10/2005 have errored out in the system and no payments have been made. These files will be regenerated by Authenticare and sent back through the system.
- **January 1, 2005** - On December 1, 2004, MDCH posted a bulletin that states the changes to the procedure codes effective January 1, 2005. For more information on this bulletin see MSA-04-24, January 1, 2005 Procedure Code Updates bulletin.
- **December 20, 2004** - Since pay cycle 48, December 1, 2004, there have been problems with the Medicare/Medicaid Crossover Claims. The Medicaid ID number that is being reported on the claims to Medicare is not being sent to Medicaid. Therefore, Medicaid is unable to process these claims because we are unaware of which provider is submitting the claims. MDCH is working with WPS to get this issue resolved and will post information on the website when the problem has been fixed. For now, providers are asked to either hold their claims if they are within the timely filing or submit their claims directly to Michigan Medicaid.
- **November 1, 2004** - The only electronic claim format that MDCH will accept from current submitters is the ANSI X12 837A1 for professional, institutional, and dental claims. For more information see the July 2004 Letter L04-19 HIPAA Update.
- **October 29, 2004** – Pended claims will no longer be appearing every 60 days on a Remittance Advice (RA). Pended claims will only reappear after they have been adjudicated. You will not need to rebill a pended claim to keep it active, you will only need to rebill, if applicable, after a

pended claim rejects. If a claim is pending longer than 6 months, please contact the Provider Inquiry line at 1-800-292-2550.

- **October 29, 2004** – Claims that completely rejected with edit 552 on Pay Cycle 40 will be automatically resubmitted in the Medicaid system. MDCH is still working on the claims that partially pend and rejected due to the 552 edit. Please be aware that if your claim correctly rejected for the 552 edit on Pay Cycle 40, it will reject again. Any questions, please contact the Provider Inquiry line at 1-800-292-2550.
- **October 5, 2004** – We have identified a system problem with edit 552 on Pay Cycle 40. This edit is setting in error causing claims to reject. Any claims that have been rejected in error will be resubmitted for you. You do not have to rebill. Watch for these claims to reappear on a future Remittance Advice. Any questions, please contact the Provider Inquiry line at 1-800-292-2550.