

# PROVIDER INQUIRER

June 1<sup>st</sup>, 2006

[www.michigan.gov/mdch](http://www.michigan.gov/mdch)

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## Healthy Kids Dental

Effective May 1, 2006, MDCH will expand the Healthy Kids Dental contract with Delta Dental Plan of Michigan. Delta Dental will administer Healthy Kids Dental in an additional 22 counties throughout the state. This will increase the number contracted to Delta Dental to 59 counties.

The 22 additional counties that have the Healthy Kids Dental program are Alcona, Alpena, Antrim, Baraga, Benzie, Crawford, Delta, Iron, Kalkaska, Lake, Leelanau, Mackinac, Manistee, Marquette, Menominee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, and Schoolcraft.

Medicaid beneficiaries under age 21 residing in these counties will be automatically enrolled in this program which provides access to Delta Dental dentists that participate in the Healthy Kids Dental program. Beneficiaries enrolled in Healthy Kids Dental receive a Delta Dental identification card. This card is not issued on a monthly basis. Dentists should call the Delta Dental Customer Services Department to verify eligibility in Healthy Kids Dental.

Providers should follow Delta Dental policy and procedures for enrolled Healthy Kids Dental beneficiaries. The services covered are the same as the Medicaid program but are administered according to Delta Dental policies.

For more information on the Healthy Kids Dental program see Bulletin MSA 06-25, Issued April 12, 2006.

For questions or comments, please contact Provider Inquiry at 1-800-292-2550 or [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov).



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## Q&A - Electronic Tertiary Claims

**Q.** "How do we handle/submit electronic tertiary claims?"

Example:

- Insurance Coverage = Medicare, BCBSM (Supplemental Policy), Medicaid.
- Submitting claims for oxygen therapy, place of service 31.
- Codes submitted E1390 RR GY and E0431 RR GY.
- Note: Medicare does not cover service; BCBSM (Supplemental Policy) does not cover service; Medicaid does cover service.

Can we submit claim to Medicaid (third payor) electronically? If so, how should our claim be formatted?" - Submitted by QHC MedBill.

**A.** An electronic 837 claim format has multiple Loops and Segments that billing agents use to submit your claims to Medicaid. Within the 837 there are specific Loops and Segments that are used for secondary and tertiary claims. At the Electronic Billing website, Medicaid has posted documents for billing agents that explains where Medicaid expects to find the secondary and tertiary information. All providers may report this information differently depending on how their billing agent needs them to report it.

For your example above, the Loops and Segments below are what would need to be reported on an 837 Professional claim to Medicaid.

- Loop 2400, Segment SV102 = Service Level Charges, total provider charges for each procedure (E1390, E0431).
- Loop 2430, Segment SVD02 = Service Level Payment, total payment provided by other insurance (this would be reported as zero for Medicare and BCBS (Supplemental Insurance) for the example above).
- Loop 2430, Segment CAS = Claim Adjustment Reason Codes, the reason codes that are reported on the EOB from the other insurances. If you do not bill other insurances because it is a non-covered procedure, the reason code that needs to be used would be 96.

Loop 2430 will need to be repeated for each other insurance that the beneficiary has. Therefore if it is a tertiary claim, Loop 2430 will be reported twice: A Medicaid secondary claim. Loop 2430

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## What's New



### Institutional Type of Bill

Beginning Pay Cycle 20, MDCH is implementing a new edit that will notify providers if an invalid type of bill was submitted on an outpatient claims. MDCH edit 638, "Invalid Type of Bill", will be informational only at this time and will not reject your claim. This is one of the many changes that MDCH is making to accommodate for the National Provider Identifier (NPI).

MDCH suggests that all outpatient providers that are receiving this edit should review the type of bill on their claims that are being sent to MDCH. Valid type of bills for outpatient hospitals include: 13X, 14X, 34X, 72X, 74X, 75X, or 85X.

On an Institutional UB-92 claim form the type of bill is located in form locator 4. On an 837 Institutional electronic claim the type of bill is in Loop 2300, Segment CLM05.

For more information on the valid types of bills, review section I of your UB-92 Manual. For questions or comments please contact Provider Inquiry at 1-800-292-2550 or [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov).

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## COMING SOON! NEW MMIS SYSTEM!

Information will be available in the July 2006 Provider Inquirer.  
ONLINE DIRECT DATA ENTRY for claims is coming!!!

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## New Q&A Sections

Medicaid would like to thank the two providers that submitted questions last month to be published in the Provider Inquirer. Any questions that are submitted will appear within the newsletter, see example to the right, in the blue boxes and they will have "Q&A" before the title. Please be sure to review these questions and answers.

Providers may add information to any question or answer, to do so please submit an email for additional comments. Please include the Question that you are referring to within your email.

If you have other questions that you would like to see posted in an upcoming newsletter please submit all questions to [ProviderOutreach@michigan.gov](mailto:ProviderOutreach@michigan.gov). Make sure to include "Provider Inquirer Question" as the subject line.

If you do not wish for your name or company name to be published, please include that in your request. As well as whether you would like a Medicaid representative to answer your question, or if you want your question posted for other providers to respond to.

## Q&A - Other Insurances

**Q.** "We often get rejections from Medicaid stating there is another insurance primary. Below is the rejection it will list the insurance and the type will say pharmacy. If we are billing a medical claim why would the claim reject for other insurance when it clearly states the insurance is for pharmacy coverage?" - Submitted by Tracy at Portage Health.

**A.** Medicaid's current system does not distinguish between different types of insurance coverage. Vision, Dental and Pharmacy as well as others are all treated the same at Medical coverage. Unfortunately if the Medicaid beneficiary has these types of coverage they must be reported on the claim so the claim will not reject for the other insurance. When the claim is received within the claims processing area, we understand that pharmacy insurance will not cover medical expenses and the edit will then be bypassed. However, if that insurance is not reported on the claim, the claim will not make it into the claims processing area.

## Beneficiary Co-Payments

Effective on Pay Cycle 19, May 10, 2006, MDCH implemented the Beneficiary Co-Payment Policy. This policy is described in Bulletin MSA 06-17. For dates of service May 1, 2006 or greater, when a co-payment has been taken, your RA will reflect MDCH edit 088.