Disclaimer

The following presentation is accurate as of the posting date in accordance with Medicaid policy and correct claim completion rules. To obtain updates and more detailed policy information please review the Michigan Medicaid Provider Manual and Policy bulletins.
Agenda

- Prior Authorization
- Secondary claims
- Billing Tips
- Issues
- Top Denials
- Managing Claims
- One-on-One session in the afternoon
• “Blanket” Prior Authorizations
  • A "Blanket" Prior Authorization (PACER or Transplant Authorization) authorizes the admission to a non-emergency inpatient admission, transfer, or readmission and related services
  • In some cases, a procedure-specific Prior Authorization is also required
PA (cont.)

- Error associated with Blanket Prior Authorizations
  - Only billing NPI on claim was being validated against the requesting and servicing NPIs in PA causing denials

- CARC B13, RARC N185
PA (cont.)

- PA
  - CARC: 29, 15, 133
  - RARC: M62, N10, N54

- MPRO Blanket: Defect was reported for institutional providers
  - Work around- The edit has been switched to pend for IPH and OPH claims. If claim denied, you could resubmit. Projected fix in June!

- Verify claim’s DOS
PA (cont.)

- PA for CSHCS
  - **CARC 15** - CSHCS claims & pacer#
  - No Pacer required for beneficiaries that are dually eligible for CSHCS and Medicaid, and the admission is related to the CSHCS qualifying condition
    - Principle Diagnosis and Admitting Diagnosis should fall under qualifying condition

**Note**- Effective DOS 5/1/2010 and after, Policy will require pacer for dual eligibility for elective admissions. Refer to Bulletin MSA 10-11
PA (cont.)

- Newborn readmission or transfer pacer number
  - Pacer number should be obtained under baby’s ID number. MPRO will grant retro auth for newborn baby. Providers cannot obtain pacer under mom’s ID number.
PA (cont.)

- PA
  - CARC15
  - CARC 7
- The authorization number is missing
- PA not reported on claim. Check software for correct loop and segment (Loop 2300 REF*G1 Qualifier)
- Your NPI number was not assigned to the PA
- Incorrect Beneficiary ID number
PA (cont.)

- **Reminder**: When requesting a modification/change to an original PA, providers must contact the Prior Authorization Unit via the following:
  - Fax: (517) 335-0075
  - Mail: MDCH Prior Authorization Division
    PO Box 30170 Lansing, MI 48909

- Include a cover letter stating: The specific changes needed, and copies of the PA or approval letter of the PA you want changed
Questions?
Secondary Claims
Secondary Claims (cont.)

- What are Claim Adjustment Source (CAS) Codes?
  - HIPAA Claim Adjustment Reason Codes are also used as CAS codes
  - CAS codes: identify the detailed reason why an adjustment was made
    - These codes replace the need for an EOB
  - CAS codes are **only** used when submitting via Direct Data Entry (DDE) through CHAMPS, or any other electronic method (billing agents, clearinghouse, etc.)
  - Always include the corresponding dollar value with the appropriate CAS code
Secondary Claims (cont.)

- Common CAS/Reason Codes
  - 1 = Deductible Amount
  - 2 = Coinsurance Amount
  - 3 = Co-pay
  - 45 = Contractual amount
  - 96 = Non-covered charges
  - 119 = Benefit maximum for this time period or occurrence has been reached.

Complete list:
- [www.wpc.edi.com/codes](http://www.wpc.edi.com/codes) >> Claim Adjustment Reason Codes
Secondary Claims (cont.)

Secondary Claims Paying $0.00:
- Service may be covered by another payer
- Medicare paid more than the MDCH allowable amount. Therefore the claim is accurately paid at $0.00
- Defect- Some claims paid $0.00 but it should reject based on eligibility

Possible Associated Codes: CARC 22, CARC 45
Secondary Claims (cont.)

- Providers should report Other Insurance (OI) on the claim when the primary plan excludes the services (vision only, dental only, etc.)
  - CAS code 96 should be reported for non-covered services by primary payer
Secondary Claims (cont.)

- CAS codes should be reported
  - for IPH claims report in the header

- **Capitated Payments**
  - Report the payment on the claim
    - Could appear on EOB as the following: “prepaid capitated service“, "risk withhold“, "reward pool" or CARC 24 with an amount or a paid amount
  - If primary ins reports Allowed Amount, CARC 45, CARC 24 with no payment, calculate the appropriate payment amount
  - Report CAS Code 1 for deductible or 2 for co-insurance
  - If all charges applied to co-insurance, report CAS 2 along with CAS 45
Secondary Claims (cont.)

Secondary Claim Processing Errors

- Patient has INCAR-MA, Inpatient services should be covered. IPH claim is denying incorrectly. Corrected in March.
  - Claims affected by this issue may be resubmitted

- Claims are denying for PA, when it is an emergency admission and Medicare is primary (per policy no PA is required)
  - Claim should bypass when OI made payment (including $0.00) Projected fix in June.
Questions?
Billing Tips
Billing Tips

- When sending documents via EZ Link, please look for confirmation that MDCH received it. MDCH has been seeing claims that indicate in the remarks that EZ Link documents were sent but when we go to EZ Link to retrieve them there is nothing there.
- If documentation is not required, do not use EZ-Link.
- Other insurance EOBs should only be submitted to Documentation EZ-Link for Medicare Part C. The Claim must also reflect the appropriate primary insurances CAS/Reason codes.

Note: For more information regarding Documentation EZ Link visit [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders) >>Documentation EZ Link
Billing Tips (cont.)

- All Institutional claims require:
  - Attending physician’s NPI number
  - Admit source
  - Patient Status
Billing Tips (cont.)

- Ungroupable DRG/APC
- CARC: A8, 133,151
  - RARC: N30
- Report valid revenue codes
- Report valid diagnosis code based on admit date
Billing Tips (cont.)

- Providers cannot report decimal points in their diagnosis codes in CHAMPS.
- All diagnosis codes must be in effect on the admission date for inpatient claims.
- To determine DRG, make sure that diagnosis codes used are the most appropriate diagnosis codes.
- If billing too many NOC diagnosis codes will cause claims to reject because the system cannot set a DRG.
Billing Tips (cont.)

- Newborn diagnosis codes- effective 10/1/09 some Dx codes (e.g. 76523, 76514, 769, 76515, 76522, 77931) no longer have an age restriction. Update was not done until 11/24/09 so some claims prior to that may have denied in error.

- Admit Source 4 (Extramural Birth): provider can report it now.
Billing Tips (cont.)

- Benefit Exhausts prior to or during stay
  - Report Occ. code A3 and date primary insurance exhausted
  - Report part B payment
  - Report non-covered days with value code 81
  - Report CAS code 119 and the amount not covered by primary payer
Billing Tips (cont.)

- Benefit effective during a stay
  - Report Occurrence Code A2 and date primary insurance became effective
  - Report any payment
  - Report non-covered days with value code 81
  - Report CAS code 1 and/or 2 and 119 with the amount
Billing Tips (cont.)

- Billing LTR and Co-ins Days
  - Co-ins days- Report value code 82
  - LTR- Report value code 83
  - Covered days- Report value code 80
  - Non-covered days with value code 81

- HIPPA 837- Electronic claims
  - Claim Qty Loop 2300 - QTY 01 for reporting Covered, LTR, Co-Ins and Non Covered days
Billing Tips (cont.)

- Medicaid LOA Days, when two related-inpatient accounts are combined, for one DRG Payment.
  - Report Admission date from 1\textsuperscript{st} admission
  - Report “From” date from 1\textsuperscript{st} admission & “To” date from 2\textsuperscript{nd} admission
  - Combine and report all charges from both admissions
  - Report RC 0180 with number of LOA days
  - Report LOA days in the Remark
Billing Tips (cont.)

To calculate LOA days

- Includes 1\textsuperscript{st} day of discharge date from 1\textsuperscript{st} admission
- Do not include 2\textsuperscript{nd} admission date
- Example
  - 1\textsuperscript{st} admission 1/1/2010 through 1/10/2010
  - 2\textsuperscript{nd} admission 1/15/2010 through 1/20/2010
  - DOS= 1/1/2010 through 1/20/2010
  - RC 0120 with unit 14
  - RC 0180 with unit 5
  - Occurrence Span Code 74, date (1/10/2010-1/14/2010)
Billing Tips (cont.)

- Claims with HMO, FFS, CSHCS eligibility in one admission
- Submit claim to HMO for the HMO covered days
- How to report to Medicaid for FFS/CSHCS covered days after HMO payment?
  - Report admission date as actual admission
  - Report “From” and “To” dates as FFS/ CSHCS covered days
  - In Remark report:
    - Entire DOS
    - Total charges of the stay
    - The HMO covered dates
    - HMO payment
Billing Tips (cont.)

- Claims with DOS span over fiscal years, causing diagnosis rejections
- MDCH edits off of the admit date for Dx codes

Note: MDCH realizes this is different than most other payers (Medicare/BCBS) - who use the discharge date for validating Dx codes and is considering this potential policy/billing change as it moves towards accepting Institutional Crossovers later this year.
Billing Tips (cont.)

- Billing Medicaid, for 15 Day Readmissions not related, which are being paid out-of-order
- Report 2\textsuperscript{nd} admission with
  - Pacer for readmission
  - Occurrence Code 71 with previous admission dates
- Claims out of sequence will suspend and claim processing will verify and process the claim even if it was paid out of sequence
Billing Tips (cont.)

- Are Abortion diagnosis codes (ex. Legal, Spontaneous, Threatened, or Incomplete) payable by Medicaid?
  - Documentation is required, and these claims will need to be manually reviewed
Billing Tips (cont.)

- Most common diagnosis codes require manual review with supporting documentation
  - 6350x-6359x
  - 6360x-6369x
  - 6370x-6379x
  - 7796
Billing Tips (cont.)

- County Jail Incarcerated Beneficiaries, with LOC-32
  - IPH- submit claim to FFS
  - OPH- submit claim to County jail contracted insurance (BCBS)
Billing Medicaid for Transplant Donor Payments.

- If the donor and beneficiary are both Medicaid eligible, the services must be billed under each beneficiary's respective ID Number.
- If only the beneficiary is Medicaid eligible, bill services for both donor and beneficiary under the Medicaid beneficiary’s ID Number.
- The letter of authorization for the transplant from the Office of Medical Affairs (OMA) or MHP must be attached to all transplant claims, otherwise, payment is denied.
Billing Tips (cont.)

- Substance abuse/psych Dx when patient is treated in ER
- If primary Dx is related to substance abuse/ psych then you can bill IP claim to Medicaid
  - Otherwise MHP is responsible for the claim
- Most of 291x, 292x, 303x-305x are related to substance abuse/psych Diagnosis
  - These claims are subject to auditing for appropriate coding
- Inpatient psych hospital would be billed to the CMH. Inpatient medical surgery for drug or psych rehab is billed to Medicaid
Billing Tips (cont.)

- Spenddown vs. Patient Pay
  - Spenddown is for part B and bene will not have coverage till spenddown (deductible) amount met
    - Report value code 66 and amount of the services rendered and made patient eligible (Letter issues from caseworker if portion of your charges applied against deductible)
  - Patient Pay amount is for part A (ex. Inpatient, Nursing facility services)
    - Report Value code D3
Billing Tips (cont.)

- Sterilization and consent forms will take up to 7 business days to process (before a claim is even processed)
- Once we receive the form and review it we send provider a message if it's approved or rejected via EZ-Link or fax depends on how provider sends it to us
  - Need help with using EZ-Link?
    - EZ Link helpdesk number (866) 373-0878
- When sending documentation EZ Link, provider must state in remarks about the attachments
Billing Tips (cont.)

- Claim Inquiry: Helpful Hints
  - Only the Header TCN can be inquired (this number ends in 00 or 000)
  - Wild card is the % sign
    - This cannot be used in the first “filter by” drop down
    - The more wildcards used in a search, the slower the results
  - From/To Dates (Date of service) and all date range inquiries are only available in the first “filter by”
  - Use the “Save to XLS” button to export results to an Excel spreadsheet
    - Pop up Blocker and Firewalls must be off or removed prior to use (see CHAMPS Website > Resources Table for more information about System Settings)
- Claim Inquiry is for “statusing” only, data cannot be altered
Questions?
Issues
QMB Claims

- QMB claims for Medicare non-covered services will not deny, they will pay $0.00. Projected fix in June!
- If Medicare doesn't cover the service, we have no liability for these beneficiaries.
CARC 6

- CARC 6 - The procedure/revenue code is inconsistent with the patient's age
  - PSYCH REVENUE CODE IS NOT COVERED FOR BENEFICIARY AGE

- Logic for edit is setting incorrectly, it is denying IPH claims but should only set on State Psych and Private Mental Hospitals. Until fixed claim will be suspend for IPH so processing can force- upcoming fix!
Top Denials

HIPAA Reason and Remark Codes
Definition: This care may be covered by another payer per coordination of benefits

Description: The beneficiary may not be eligible for Michigan Medicaid on date of service, or the beneficiary has other insurance - If other insurance was reported on the claim then this reason code is informational only
CARC 22 (cont.)

- **Resolution**: Verify Eligibility
  - Other Insurance:
    - Currently all “Other Insurance” for the Date of Service MUST be reported on the claim
    - Secondary/Tertiary Claims **CAN** be sent electronically without EOB attachments
      - If using the (DDE) tool, use the Payer/Carrier IDs reported within the “Commercial/Other” hyperlink within the CHAMPS “Member” subsystem
      - Report appropriate CAS/ Reason codes
  - **Associated RARC**: N36, N196, N4, MA04, N48
CARC 18

- **Definition:** Duplicate claim/service
- **Description:** Suspected or exact duplicate of a paid claim in the system history
- **Resolution:** If determined to be a valid claim, verify the dates of service and re-bill or void previously paid claim
- **Do not submit multiple duplicate claims if initial claim has been suspended**
- **Associated RARC:** N30, M86, N10
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**Definition:** The impact of prior payer(s) adjudication including payments and/or adjustments

**Description:** Billed amount exceeds Medicaid Fee Screens

**Resolution:** See Fee Screens for Medicaid allowable amounts

**Possible RARC:** MA04, N48, N131
**Definition:** Charges are covered under a capitation agreement/managed care plan

**Description:** The beneficiary is enrolled in a Medicaid Health Plan. The provider should contact the Medicaid Health Plan for reimbursement

**Resolution:** Check Eligibility for DOS, and submit claim to Medicaid Health Plan

**Possible RARC:** N185, N130
CARC 31, MA61

- **Definition:** CARC 31-Patient cannot be identified as our insured RARC MA61-Missing/incomplete/invalid social security number or health insurance claim number
- **Description:** Invalid beneficiary ID number
- **Resolution:** Providers need to validate beneficiary number
CARC 15, N54

- **Definition:** CARC 15- The authorization number is missing, invalid, or does not apply to the billed services or provider RARC N54- Information is inconsistent with pre-certified/authorized services

- **Description:** Claim date of service (DOS) is not within PA date of service or claim data does not match PA

- **Resolution:** Verify PA submitted on claim is accurate and valid for DOS

**Reminder:** PA for newborns must be obtained under the newborns beneficiary ID and NOT the mother’s ID number
**Definition:** CARC 16- Claim/service lacks information which is needed for adjudication RARC M47-Missing/Incomplete/Invalid internal or document control number

**Description:** Provider did not use a valid or last paid TCN for adjustment

**Resolution:** Use claim inquiry function within CHAMPS, to locate appropriate TCN
Carc 111, n47

- **Definition:** Carc111- The disposition of this claim/service is pending further review, RARC N47- Claim conflicts with another inpatient stay
- **Description:** Beneficiary readmitted within 15 days
- **Resolution:** Must report occurrence span code 71, prior admission date, and appropriate Pacer Number
**Definition:** CARC 109- Claim not covered by this payer/contractor RARC N193-Specific federal/state/local program may cover this service through another payer

**Description:** Beneficiary is enrolled in a mental health or substance abuse plan

**Resolution:** Verify beneficiary eligibility and bill appropriately
CARC 133

- **Definition:** The disposition of this claim/service is pending further review

- **Description:** Claim previously pended for further review per policy or denied per policy

- **Resolution:** The code is an informational reason code, providers should view the “category” or “status” of the claim to determine its final disposition. If claim denied, review associate RARC for further clarification
CARC 16, N253

- **Definition:** Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

- **Description:** Documentation, and/or other important claim details were omitted

- **Resolution:** Verify that your Attending Provider NPI is valid and is reported, consent form(s) have been sent, or other required documents
Questions?
Managing Claims

Adjustments and Voids
Manage Claims

Adjust Claims
Choose an Option:

- Adjust/Void Claim Provider

Path: Provider Portal/ Provider Portal
<table>
<thead>
<tr>
<th>Header Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCN: [redacted]</td>
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<tr>
<td>Original TCN: [redacted]</td>
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<tr>
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<tr>
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<tr>
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<tr>
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</tr>
<tr>
<td>Operating Provider ID: [redacted]</td>
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<td>Pay To Provider ID: [redacted]</td>
</tr>
<tr>
<td>Attending Provider ID: [redacted]</td>
</tr>
<tr>
<td>Other Provider ID: [redacted]</td>
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<tr>
<td>Total DRG Outlier Payment: [redacted]</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Patient Status: 30-Still patient</td>
</tr>
<tr>
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</tr>
<tr>
<td>Admit Type: [redacted]</td>
</tr>
<tr>
<td>Discharge Hour: 00:00 (HH:MM)</td>
</tr>
<tr>
<td>Principal Diagnosis Code: 2691 POA: U-Unknown</td>
</tr>
<tr>
<td>E.Code: [redacted] POA: [redacted]</td>
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<tr>
<td>Other Diagnosis Code: V4611 POA: U-Unknown</td>
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<tr>
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<tr>
<td>Related Cause: [redacted]</td>
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<td>Situational Information: [redacted]</td>
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<td>Service Line List: [redacted]</td>
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<tr>
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<tr>
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<tr>
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</tr>
<tr>
<td>3209299110011111002</td>
</tr>
<tr>
<td>3209299110011111003</td>
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### Service Line List - Microsoft Internet Explorer

**Header TCN:**

**Beneficiary ID:**

**Name:**

**Show:** --SELECT--

---

**Service Lines:**

**Filter By:**

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<th>TCN</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Submitted Charges</th>
<th>Approved Amount</th>
<th>Claim Status</th>
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<td>01/14/2009</td>
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<td>$0.00</td>
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**Microsoft Internet Explorer**

**Are you sure you want to delete service line?**

- **Cancel**
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<tr>
<th>TCI</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
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**Service Line Detail:**

- **TCN:**
- **Claim Type:**
- **Source:** Web
- **Bill Type:** [0 3 3 7]
- **Claim Status:**

- **Beneficiary ID:**
- **Gender:** Female
- **DOB:** 05/07/1922
- **Benefit Plan:**
- **Age:**

- **Operating Provider ID:**
- **Type:**
- **Taxonomy:**
- **Auth #:**
- **Service From Date:**
- **Service To Date:**

- **Procedure Code:**
- **APC Code:**
- **APC Status:**
- **Total APC Outlier Payment:**
- **Revenue Code:**
- **Rate:**
- **Modifiers:** 1: [ ] 2: [ ] 3: [ ] 4: [ ]
- **Manual Units:**
- **Billed Units:**
- **Paid Units:**

- **Submitted Charges:**
- **Billed Amount:**
- **Approved Amount:** $0.00
- **Medicare Paid:**
- **Medicare Co-insurance:**
- **Medicare Deductible:**
- **Other Insurance:**
- **Other Insurance Co-Pay:**
- **Other Insurance Deductible:**
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- **Claim Type:** [redacted]
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- **Claim Status:** In Process
- **Beneficiary ID:** [redacted]
- **Gender:** Female
- **Benefit Plan:** [redacted]
- **Operating Provider ID:** [redacted]
- **Taxonomy:** 251E00000X
- **Other Provider ID:** [redacted]
- **Auth #:** [redacted]
- **Service From Date:** 07/08/2009
- **Service To Date:** 07/08/2009
- **Procedure Code:** G0154
- **APC Code:** [redacted]
- **APC Status:** [redacted]
- **Total APC Outlier Payment:** [redacted]
- **Rate:** $80.98
- **Revenue Code:** 0551
- **Manual Units:** [redacted]
- **Manual Price:** [redacted]
- **Submitted Charges:** $175.00
- **Medicare Paid:** [redacted]
- **Billed Amount:** [redacted]
- **Approved Amount:** $50.00
- **Medicare Co-insurance:** [redacted]
- **Medicare Deductible:** [redacted]
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<tbody>
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<td></td>
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<td>P-Primary</td>
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<td>NIB: Medicare Part B</td>
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<td>P-Primary</td>
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<td>No Records Found!</td>
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**Header Details:**

- **TCN:** [redacted]
- **Original TCN:** [redacted]
- **Bill Type:** [redacted]
- **Adjustment Source:** [redacted]
- **Beneficiary ID:** [redacted]
- **Gender:** [redacted]
- **Patient Control Number:** [redacted]
- **Benefit Plan:** [redacted]
- **Claim Type:** Z - Home Health
- **No of Lines:** 11
- **Medicare:** N
- **Pricing Rule:** [redacted]
- **Commercial:** N
- **Claim Status:** Paid
- **Last Name:** [redacted]
- **DOB:** 09/30/1981
- **First Name:** [redacted]
- **Medical Record Number:** [redacted]

**Billing Provider ID:** [redacted]
**Type:** NPI

**Operating Provider ID:** [redacted]
**Type:** [redacted]

**Pay To Provider ID:** [redacted]
**Type:** [redacted]

**Other Provider ID:** [redacted]
**Type:** [redacted]

**Total DRG Outlier Payment:** [redacted]

**Patient Status:** 30 - Still Patient
**Admit Source:** [redacted]
**Admit Type:** [redacted]
**Discharge Date:** 00:00 (HH:MM)
**Discharge Hour:** [redacted]

**Principal Diagnosis Code:** 2691
**POA:** U-Unknown
**E.Code:** [redacted]
**Other Diagnosis Code:** [redacted]
**POA:** U-Unknown
**Manual Price:** [redacted]

**Submitted Charges:** $1,000.00
**Medicare Paid:** [redacted]
**Other Insurance:** [redacted]
**Warrant/EFT Number:** [redacted]

**Billed Amount:** $1,000.00
**Medicare Co-Insurance:** [redacted]
**Other Insurance:** [redacted]
**Co-Insurance/CoPay:** [redacted]
**RA Number:** [redacted]

**Taxonomy:** 251E00000X
**Auth #:** [redacted]
**Auth #:** [redacted]
**From Date:** 03/03/2009
**To Date:** 03/31/2009
**DRG Code:** [redacted]

**Admit Date:** [redacted]
**Admit Hour:** [redacted] (HH:MM)
**Days Billed:** [redacted]
**Covered Days:** [redacted]
**Non Covered Days:** [redacted]
**Reason For Visit:** [redacted]
**LR Days:** [redacted]
Manage Claims

Void Claims
### Choose an Option:

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<th>Option</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Claim Submission</td>
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<td>RA List</td>
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<tr>
<td>Choose an Option:</td>
<td>Adjust/Void Claim Provider</td>
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<tr>
<td>Adjust/Void Claim Provider</td>
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</table>
No Records Found!

### Header Details

- **TCN:** [Redacted]
- **Original TCN:** [Redacted]
- **Bill Type:** [Redacted]
- **Adjustment Source:** [Redacted]
- **Beneficiary ID:** [Redacted]
- **Gender:** [Redacted]
- **Patient Control Number:** [Redacted]
- **Benefit Plan:** [Redacted]
- **Claim Type:** Z - Home Health
- **No of Lines:** 11
- **Medicare:** Y
- **Pricing Rule:** [Redacted]
- **Claim Status:** Paid
- **Commercial:** N
- **Related Cause:** [Redacted]
- **Last Name:** [Redacted]
- **DOB:** 09/30/1981
- **First Name:** [Redacted]
- **Medical Record Number:** [Redacted]

### Billing Provider ID

- **Type:** NPI
- **Taxonomy:** 251E0000X

### Operating Provider ID

- **Type:** [Redacted]

### Pay To Provider ID

- **Type:** [Redacted]

### Attending Provider ID

- **Type:** [Redacted]

### Other Provider ID

- **Type:** [Redacted]

### Total DRG Outlier Payment

- **Amount:** [Redacted]

### Patient Status

- **Status:** 30-Still patient
- **Admit Source:** [Redacted]
- **Admit Type:** [Redacted]
- **Discharge Hour:** 00:00 (HH:MM)
- **Principal Diagnosis Code:** 2691
- **POA:** U-Unknown
- **E-Code:** [Redacted]
- **Other Diagnosis Code 1:** V4611
- **POA:** U-Unknown
- **Other Diagnosis Code 2:** V4411
- **POA:** U-Unknown

### Submitted Charges

- **Amount:** $1,000.00

### Billed Amount

- **Amount:** $1,000.00

### Approved Amount

- **Amount:** $5624.58

### Medicare

- **Paid:** [Redacted]
- **Deductible:** [Redacted]
- **Other Insurance:** [Redacted]
- **Deductible:** [Redacted]
- **Paid Date:** [Redacted]
- **Co-Insurance/CoPay:** [Redacted]
- **RA Number:** [Redacted]
Managing Claims through Billing Agent or 837 File

- Resubmit claim in its entirety in the same manner it should have been submitted originally.
- Enter a Resubmission or Claim Frequency Type Code of 7 if adjusting or an 8 if voiding a claim.
  - Loop 2300 CLM05-3
- Enter last paid TCN or 15 digit converted CRN (ends with 00 or 000) in Loop 2300 REF with Qualifier F8.
- A new 18 digit TCN will be generated, once adjustment has been processed.
Adjustment (continued…)

- Adjustment claims- how they are being processed with 117 and 118 bill types?
- CHAMPS creates one claim with TCNxxxxxxxx8 (take back/ credited) then another one with TCNxxxxxxxx7 (new payment)
<table>
<thead>
<tr>
<th>TCN</th>
<th>Beneficiary ID</th>
<th>Billing Provider NPI</th>
<th>Claim Type</th>
<th>From Date</th>
<th>To Date</th>
<th>Submitted Charges</th>
<th>Claim Status</th>
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<tr>
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<td>1011223344</td>
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<td>01/01/2010</td>
<td>01/01/2010</td>
<td>$1,569.50</td>
<td>Credited</td>
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</table>
Questions?
Payment Error Rate Measurement

PERM

- PERM is a regulation issued by CMS as a result of the 2002 Improper Payments and Information Act (IPIA)
- PERM measures improper payments for State Medicaid programs and State Children’s Health Insurance Programs (SCHIP)
- A random sample of paid claims are selected for review
- MDCH will publish a bulletin soon regarding PERM
How Does PERM Work?

- **Livanta LLC** has been selected as the National contractor that will contact providers to collect medical record documentation pertinent to the selected paid claims.
- Providers **must** submit the requested medical record documentation with 60 days.
- Failure to comply with the request(s) is considered payment error. Michigan Medicaid will incur a penalty and may recoup the payments that were made on the selected claims from the providers.
Questions?
Claim Examples
### Occurrence Codes List

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<tr>
<th>Occurrence Code</th>
<th>Occurrence Name</th>
<th>From Date</th>
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### Occurrence Span Codes List

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<th>Occurrence Span Code</th>
<th>Occurrence Name</th>
<th>From Date</th>
<th>To Date</th>
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</table>

### Value Codes List

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### Condition Codes List

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<th>Description</th>
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<tbody>
<tr>
<td>38</td>
<td>Private Room Medically Necessary</td>
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### Patient Information

- Patient Status: D1-Dischrgd to h/h/self or (dn)
- Admit Source: E-Emergency room
- Admit Type: I-Emergency
- Admit Date: 1/3/2010
- Discharge Hour: 8:00 (HH:MM)
- Principal Diagnosis Code: 27762
- POA: Y-Yes
- Admitting Diagnosis Code: 76669
- Covered Days: [Highlighted]
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- **Payer ID through 837 (not DDE)**
- **Primary Insurance**
- **Primary payer**
- **Coins amount**
- **Write off/contraction amount**
### Patient Information

- **Patient Status:** Discharged to Inpatient (in)
- **Admit Source:** Emergency room
- **Admit Type:** Emergency
- **Admit Date:** 01/30/2010
- **Discharge Hour:** AM/PM
- **Discharge Date:** 01/30/2010
- **Principal Diagnosis Code:** 45121
- **E-Code:**
- **Other Diagnosis Code:** 42833, 4849

### Claim Details

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Questions?

30 minute, One-on-One session in the afternoon