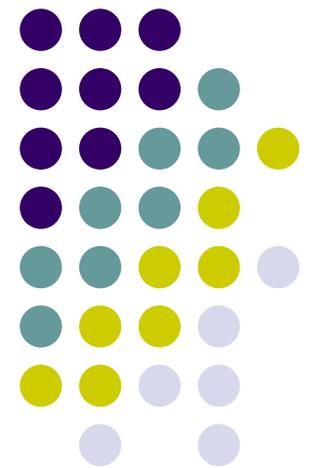


# Inpatient Hospital Billing Session

2010





# 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

# PA



- “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.)

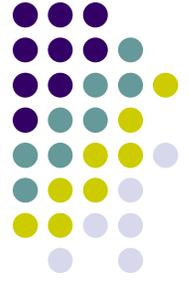
- PA
  - CARC: 29, 15, 133
  - RARC: M62, N10, N54
- MPRO Blanket: Defect was reported for institutional providers
  - Work around- The edit has been switched to pend for IPH and OPH claims. If claim denied, you could resubmit. Projected fix in June!
- Verify claim's DOS



## 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

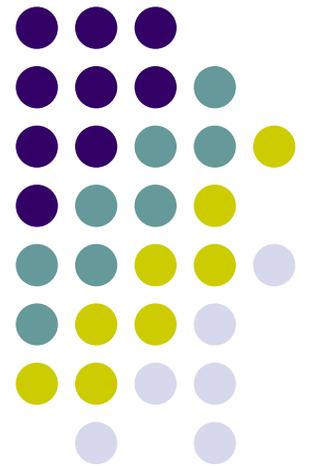


## PA (cont.)

- **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

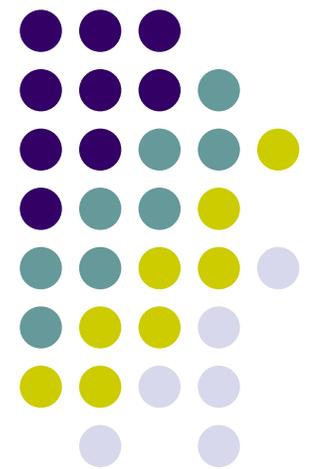
# Questions?

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# Secondary Claims

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## 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

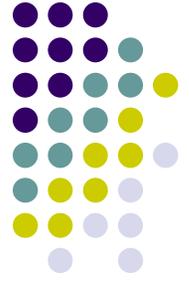


## Secondary Claims (cont.)

### 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



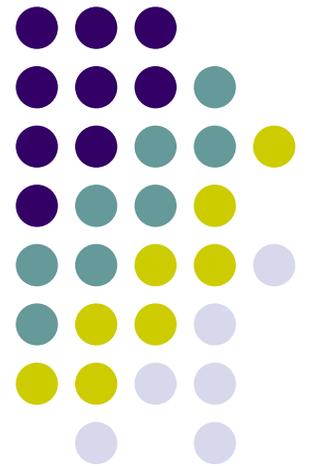
## Secondary Claims (cont.)

### 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.

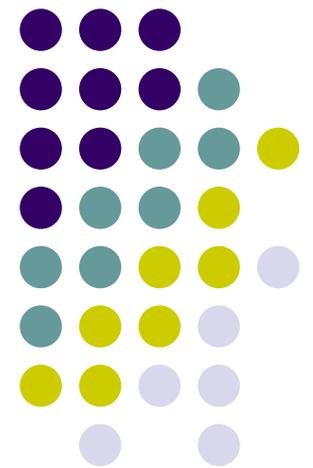
# Questions?

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# Billing Tips

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# 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 can not 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 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



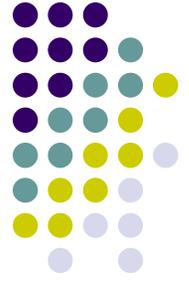
## Billing Tips (cont.)

- 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



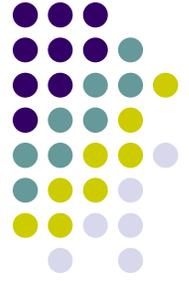
## Billing Tips (cont.)

- 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



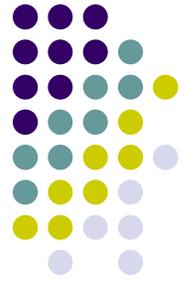
## Billing Tips (cont.)

- 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<sup>st</sup> admission
  - Report “From” date from 1<sup>st</sup> admission & “To” date from 2<sup>nd</sup> 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<sup>st</sup> day of discharge date from 1<sup>st</sup> admission
  - Do not include 2<sup>nd</sup> admission date
  - Example
    - 1<sup>st</sup> admission 1/1/2010 through 1/10/2010
    - 2<sup>nd</sup> 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.)

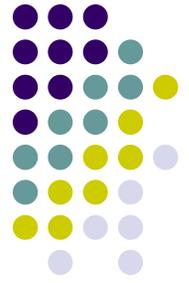
- Claims with HMO, FFS, CSHCS eligibility in one admission
- Submit claim to HMO for the HMO covered days
- How to report to Medicaid for FFS/CSHCS covered days after HMO payment?
  - Report admission date as actual admission
  - Report “From” and “To” dates as FFS/ CSHCS covered days
  - In Remark report:
    - 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.



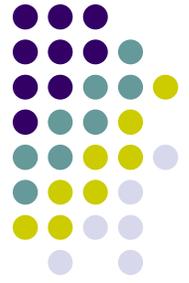
## Billing Tips (cont.)

- Billing Medicaid, for 15 Day Readmissions not related, which are being paid out-of-order
- Report 2<sup>nd</sup> 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



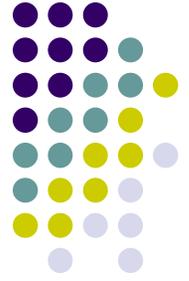
## Billing Tips (cont.)

- 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 Tips (cont.)

- **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



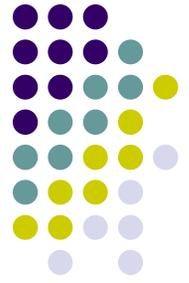
## Billing Tips (cont.)

- 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

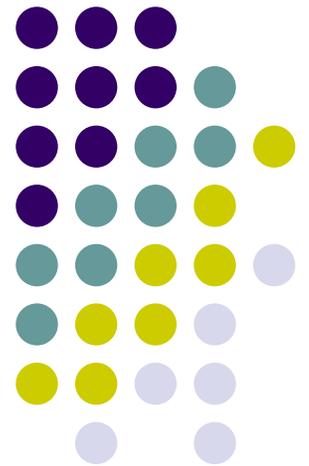


# Billing Tips (cont.)

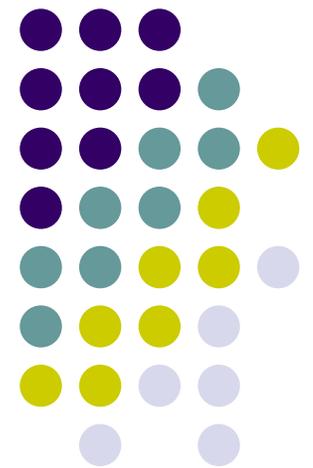
- Claim Inquiry: Helpful Hints
  - Only the Header TCN can be inquired (this number ends in 00 or 000)
  - Wild card is the % sign
    - This cannot be used in the first “filter by” drop down
    - The more wildcards used in a search, the slower the results
  - From/To Dates (Date of service) and all 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?

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# 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

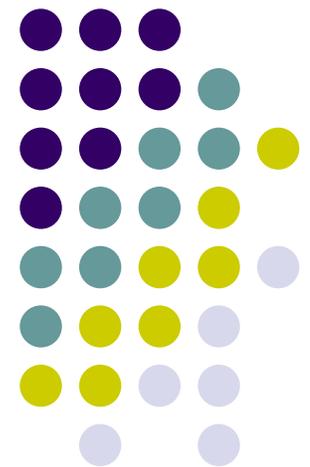


## CARC 6

- 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



# CARC 22



- **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

Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED]

Name: GRUWRQ, IDLWK

- Show: ---SELECT---
- SELECT---
  - Claim Cutbacks
  - Claim Enhancement Amounts
  - Claim Notes
  - Codes List
  - Source
  - Diagnosis Codes
  - Indicators
  - Related Cause
  - Other Payers Information
  - Commercial
  - Related Causes
  - Service Line List
  - Claim Status
  - Situational Information

Header Details:

TCN: [REDACTED]	Claim Type: F - Outpatient OPPS	Source: [REDACTED]
Original TCN: [REDACTED]	No of Lines: 1	Related Cause: [REDACTED]
Bill Type: 0 * 1 * 3 * 4 *	Medicare: N	Commercial: [REDACTED]
Adjustment Source:	Pricing Rule: APC Pricing	Claim Status: [REDACTED]
Beneficiary ID: [REDACTED] *	Last Name: GRUWRQ	First Name: IDLWK
Gender: F-Female *	DOB: [REDACTED] *	Age: 9
Patient Control Number: [REDACTED] *	Medical Record Number: [REDACTED]	
Benefit Plan:		
Billing Provider ID: [REDACTED] Type: NPI	Taxonomy: 282N00000X	
Operating Provider ID: [REDACTED] Type:		
Pay To Provider ID: [REDACTED] Type: NPI		
Attending Provider ID: [REDACTED] * Type: NPI *	Auth #: [REDACTED]	Auth #: [REDACTED]
Other Provider ID: [REDACTED] Type:	From Date: 04/15/2009 *	To Date: 04/15/2009 *
Total DRG OutLier Payment: 0	Total APC OutLier Payment: 0	DRG Code:
Patient Status: 01-Dischrgd to hm/self or (rtn) *		
Admit Source: 2-Clinic *		
Admit Type:	Admit Hour: [REDACTED] (HH:MM)	
Admit Date:	Days Billed: [REDACTED]	
Discharge Hour: 00:00 (HH:MM)	Admitting Diagnosis Code: [REDACTED]	Reason For Visit: [REDACTED]
Principal Diagnosis Code: 07999 * POA: [REDACTED] *	Covered Days: [REDACTED]	Co Insured Days: [REDACTED]
E-Code: [REDACTED] POA: [REDACTED]	Non Covered Days: [REDACTED]	LR Days: [REDACTED]
Other Diagnosis Code: [REDACTED] POA: [REDACTED]		
Other Diagnosis Code: [REDACTED] POA: [REDACTED]		
Manual Price: [REDACTED]		
Submitted Charges: \$43.00 *	Billed Amount: \$43.00	Approved Amount: \$0.00
Medicare Paid: [REDACTED]	Medicare Co-Insurance: [REDACTED]	Medicare Deductible: [REDACTED]
Other Insurance: [REDACTED]	Other Insurance Co-Insurance/CoPay: [REDACTED]	Other Insurance Deductible: [REDACTED]
Warrant/EFT Number: [REDACTED]	RA Number: [REDACTED]	Paid Date: [REDACTED]

Cancel

Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED]  
Name: GRUWRQ, IDLWK

Show: --SELECT--

Service Lines:

Filter By : [ ] [ ] And [ ] [ ] Go

<input type="checkbox"/>	TCN ▲▼	Revenue Code ▲▼	Procedure Code ▲▼	From Date ▲▼	To Date ▲▼	Units ▲▼	Submitted Charges ▲▼	Approved Amount ▲▼	Claim Status ▲▼
<input type="checkbox"/>	39999999999999999999	0610	89213	04/15/2009	04/15/2009	1	\$43.00	\$40.56	Paid

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Cancel

Header TCN: [REDACTED]  
 Line TCN: [REDACTED]  
 Beneficiary ID: [REDACTED] Name: [REDACTED]

- Show: ---SELECT---
- SELECT---
  - Claim Cutbacks
  - Claim Enhancement Amounts
  - Claim Header Detail
  - Claim Limit List
  - Claim Notes
  - Codes List
  - Diagnosis Codes
  - Drug Information
  - Indicators
  - Other Payers Information

Service Line Detail:

TCN: [REDACTED]	Claim Type: F - Outpatient OPPS	Source: HIPAA
Adjustment Source: Pricing Rule: APC Pricing	Bill Type: 0 * 1 * 3 * 1 *	Claim Status: Paid
Beneficiary ID: [REDACTED] Gender: Female Benefit Plan: Full Fee-for-service Medical Assistance	Last Name: GRUWRQ DOB: [REDACTED]	First Name: IDLWK Age: 9
Operating Provider ID: [REDACTED] Type: [REDACTED] Other Provider ID: [REDACTED] Type: [REDACTED] Auth #: [REDACTED] Service From Date: 04/15/2009	Taxonomy: 282N00000X Auth #: [REDACTED] Service To Date: 04/15/2009	
Procedure Code: 99213	APC Code: 805	APC Status: Y Total APC OutLier Payment: \$0.00
Revenue Code: 0510 *	Rate: [REDACTED]	Modifiers: 1: 25 2: [REDACTED] 3: [REDACTED] 4: [REDACTED]
Manual Units: [REDACTED] Manual Price: [REDACTED]	Billed Units: [REDACTED] *	Paid Units: 0
Submitted Charges: \$43.00 *	Billed Amount: \$43.00	Approved Amount: \$40.55
Medicare Paid: [REDACTED]	Medicare Co-insurance: [REDACTED]	Medicare Deductible: [REDACTED]
Other Insurance: [REDACTED]	Other Insurance Co-Pay: [REDACTED]	Other Insurance Deductible: [REDACTED]

Previous Next Cancel

Header TCN: [REDACTED]  
 Line TCN: [REDACTED]  
 Beneficiary ID: [REDACTED] Name: [REDACTED]

Show: --SELECT--

Current Claim:

TCN	From Date	To Date	Facility Type	Billing Provider NPI	Servicing Provider NPI	Procedure Code	Revenue Code	Modifiers	Billed Amount	Paid Amount	Paid Date	Units	
[REDACTED]	12/17/2009	12/21/2009	21-Inpatient Hospital	[REDACTED]			0120		\$5,468.00	\$0.00	01/28/2010	0	[REDACTED]

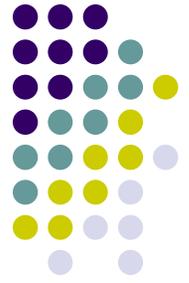
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History Claims:

TCN	From Date	To Date	Facility Type	Billing Provider NPI	Servicing Provider NPI	Procedure Code	Revenue Code	Modifiers	Billed Amount	Paid Amount	Paid Date	Units
[REDACTED]	12/21/2009	12/21/2009	41-Ambulance - Land	[REDACTED]		A0428		H,H	\$538.05	\$105.32	01/14/2010	1
[REDACTED]	12/21/2009	12/21/2009	41-Ambulance - Land	[REDACTED]		A0425		H,H	\$1,070.00	\$327.00	01/14/2010	100

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## CARC 23

- **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



## CARC 24

- **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

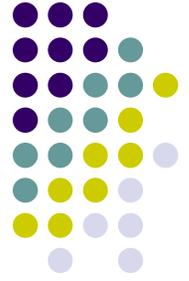


# CARC 15, N54

- **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

# CARC 16, M47



- **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

# CARC 109, N193



- **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

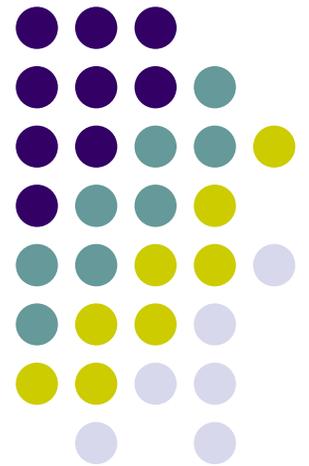
# CARC 16, N253



- **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?

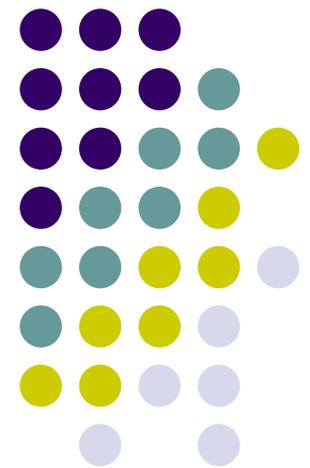
---



# Managing Claims

---

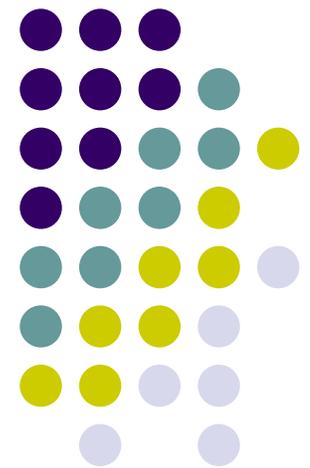
Adjustments and Voids



# Manage Claims

---

Adjust Claims





My  
Inbox

Admin

Provider

Claims

Reference

Member

TPL

Rate  
Setting

PA

Contract/MC

Welcome Provider, K. You have logged-in with [redacted] domain and CHAMPS Full Access profile.

Links: --Select--



Path: Provider Portal/ Provider Portal

NPI: [redacted]

Name: [redacted]

Menu

Provider Portal:

Online Services:

Provider

Hide/Max

- [Initiate New Enrollment](#)
- [Manage Provider Information](#)
- [Track Application](#)

Admin

Hide/Max

- [Archived Documents](#)

Claims

Hide/Max

- [Submit Institutional Claim Inquiry](#)
- [Submit Dental](#)
- [Submit Professional](#)

Member

Hide/Max

- [Eligibility Inquiry](#)

Prior Authorization

Hide/Max

- [PA Inquire](#)
- [PA Request List](#)

Welcome!

Hide/Max



My Reminders:

Filter By: [dropdown] [input] [input] Go

<input type="checkbox"/>	Alert Type	Alert Message	Alert Date	Due Date	Read
--------------------------	------------	---------------	------------	----------	------

No Records Found !



My  
Inbox

Admin

Provider

Claims

Reference

Member

TPL

Rate  
Setting

PA

Contract/MC

Welcome Provider, K. You have logged-in with [redacted] domain and CHAMPS Full Access profile.

Links: --Select--



Path: Provider Portal/ Provider Portal

Menu

Close

Choose an Option:

[Claim Submission](#)

Claim Submission

[Manage Claims](#)

Manage Claims

[Inquire Claims](#)

Inquire Claims

[RA List](#)

RA List



My  
Inbox

Admin

Provider

Claims

Reference

Member

TPL

Rate  
Setting

PA

Contract/MC

Welcome Provider, K. You have logged-in with [redacted] domain and CHAMPS Full Access profile.

Links: --Select--



Path: Provider Portal/ Provider Portal

Menu

Close

Choose an Option:

[Adjust/Void Claim Provider](#)

Adjust/Void Claim Provider





My  
Inbox

Admin

Provider

Claims

Reference

Member

TPL

Rate  
Setting

PA

Contract/MC

Welcome Provider, K. You have logged-in with [redacted] domain and CHAMPS Full Access profile.

Links: --Select--



Path: Provider Portal/ Provider Portal

Menu

Close

Adjust Claims:

TCN:





Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED]

Name: [REDACTED]

Show: ---SELECT---

- SELECT---
- Claim Cutbacks
- Claim Enhancement Amounts
- Claim Notes
- Codes List
- Diagnosis Codes
- Indicators
- Other Payers Information
- Related Causes
- Service Line List
- Situational Information

TCN ▲▼	Error Description ▲▼	Erroneous Data ▲▼
-----------	-------------------------	----------------------

No Records Found !

**Header Details:**

TCN: [REDACTED]		Claim Type: Z - Home Health	
Original TCN: [REDACTED]		No of Lines: 11	
Bill Type: 0 * 3 * 3 * 1 *		Medicare: N	
Adjustment Source:		Pricing Rule:	
Beneficiary ID: [REDACTED] *		Last Name: [REDACTED]	
Gender: M-Male *		DOB: 09/30/1981 *	
Patient Control Number: 5082 *		Medical Record Number: [REDACTED]	
Benefit Plan:		First Name: [REDACTED]	
Billing Provider ID: [REDACTED] Type: NPI		Taxonomy: 251E00000X	
Operating Provider ID: [REDACTED] Type: [REDACTED]		Auth #: [REDACTED]	
Pay To Provider ID: [REDACTED] Type: [REDACTED]		From Date: 03/03/2009 *	
Attending Provider ID: [REDACTED] Type: [REDACTED]		To Date: 03/31/2009 *	
Other Provider ID: [REDACTED] Type: [REDACTED]		Total DRG OutLier Payment: [REDACTED]	
Total DRG OutLier Payment: [REDACTED]		Total APC OutLier Payment: 0	
Patient Status: 30-Still patient *		DRG Code:	
Admit Source: [REDACTED] *		Admit Date: [REDACTED]	
Admit Type: [REDACTED]		Admit Hour: [REDACTED] (HH:MM)	
Discharge Hour: 00:00 (HH:MM)		Days Billed: [REDACTED]	
Principal Diagnosis Code: 3591 * POA: U-Unknown *		Admitting Diagnosis Code: 3591	
E-Code: [REDACTED] POA: [REDACTED]		Covered Days: 0	
Other Diagnosis Code: V4611 POA: U-Unknown		Non Covered Days: 0	
Other Diagnosis Code: V440 POA: U-Unknown		Reason For Visit: [REDACTED]	
Manual Price: [REDACTED]		Co Insured Days: 0	
Submitted Charges: \$1,000.00 *		LR Days: 0	
Medicare Paid: [REDACTED]		Billed Amount: \$1,000.00	
Other Insurance: [REDACTED]		Approved Amount: \$624.58	
Warrant/EFT Number: [REDACTED]		Medicare Co-Insurance: [REDACTED]	
		Medicare Deductible: [REDACTED]	
		Other Insurance Co-Insurance/CoPay: [REDACTED]	
		Other Insurance Deductible: [REDACTED]	
		RA Number: [REDACTED]	
		Paid Date: [REDACTED]	

Adjust Void Save Canc

Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED] Name: [REDACTED]

Show: --SELECT--

Service Lines:

Filter By : [ ] And [ ] Go

<input type="checkbox"/>	TCN ▲▼	Revenue Code ▲▼	Procedure Code ▲▼	From Date ▲▼	To Date ▲▼	Units ▲▼	Submitted Charges ▲▼	Approved Amount ▲▼	Claim Status ▲▼
<input checked="" type="checkbox"/>	320929910011111001		83036	01/14/2009	01/14/2009	1	\$25.00	\$0.00	Paid
<input type="checkbox"/>	320929910011111002		36416	01/14/2009	01/14/2009	1	\$14.00	\$0.00	Denied
<input type="checkbox"/>	320929910011111003		36415	01/14/2009	01/14/2009	1	\$14.00	\$0.00	Paid

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Add Delete Cancel

Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED] Name: [REDACTED]

Show: --SELECT--

Service Lines:

Filter By : [ ] And [ ] Go

<input type="checkbox"/>	TCN ▲▼	Revenue Code ▲▼	Procedure Code ▲▼	From Date ▲▼	To Date ▲▼	Units ▲▼	Submitted Charges ▲▼	Approved Amount ▲▼	Claim Status ▲▼
<input checked="" type="checkbox"/>	320929910011111001		83036	01/14/2009	01/14/2009	1	\$25.00	\$0.00	Paid
<input type="checkbox"/>	320929910011111002		36416	01/14/2009	01/14/2009	1	\$14.00	\$0.00	Denied
<input type="checkbox"/>	320929910011111003		36415	01/14/2009	01/14/2009	1	\$14.00	\$0.00	Paid

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

**Microsoft Internet Explorer** [X]

? Are you sure you want to delete service line?

OK Cancel

Add Delete Cancel

Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED] Name: [REDACTED]  
Show: --SELECT--

Service Lines:

Filter By : [ ] And [ ] Go

<input type="checkbox"/>	TCN ▲▼	Revenue Code ▲▼	Procedure Code ▲▼	From Date ▲▼	To Date ▲▼	Units ▲▼	Submitted Charges ▲▼	Approved Amount ▲▼	Claim Status ▲▼
<input type="checkbox"/>	410929910011111002		36416	01/14/2009	01/14/2009	1	\$14.00		In Process
<input type="checkbox"/>	410929910011111003		36415	01/14/2009	01/14/2009	1	\$14.00		In Process

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Add Delete Cancel



Header TCN: [REDACTED]  
 Line TCN:  
 Beneficiary ID: [REDACTED]

Name: [REDACTED]

Show: ---SELECT---

TCN ▲▼	Error Description ▲▼	Erroneous Data ▲▼
-----------	-------------------------	----------------------

No Records Found !

Service Line Detail:



TCN:	Claim Type:	Source: Web
Adjustment Source:	Bill Type: 0 * 3 * 3 * 7 *	Claim Status:
Pricing Rule:		
Beneficiary ID: [REDACTED]	Last Name: [REDACTED]	First Name: [REDACTED]
Gender: Female	DOB: 05/07/1922	Age:
Benefit Plan:		
Operating Provider ID: [REDACTED] Type: [▼]	Taxonomy:	
Other Provider ID: [REDACTED] Type: [▼]		
Auth #: [REDACTED]	Auth #: [REDACTED]	
Service From Date: [REDACTED]	Service To Date: [REDACTED]	
Procedure Code: [REDACTED]	APC Code: [REDACTED]	APC Status: [REDACTED]
		Total APC OutLier Payment: [REDACTED]
Revenue Code: [REDACTED] *	Rate: [REDACTED]	Modifiers: 1: [REDACTED] 2: [REDACTED]
		3: [REDACTED] 4: [REDACTED]
Manual Units: [REDACTED]	Billed Units: [REDACTED] *	Paid Units:
Manual Price: [REDACTED]		
Submitted Charges: [REDACTED] *	Billed Amount: [REDACTED]	Approved Amount: \$0.00
Medicare Paid: [REDACTED]	Medicare Co-insurance: [REDACTED]	Medicare Deductible: [REDACTED]
Other Insurance: [REDACTED]	Other Insurance Co-Pay: [REDACTED]	Other Insurance Deductible: [REDACTED]

Previous Next Save Cancel



Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED] Name: [REDACTED]  
Show: --SELECT--

Service Lines:

Filter By : [ ] And [ ] Go

<input type="checkbox"/>	TCN ▲▼	Revenue Code ▲▼	Procedure Code ▲▼	From Date ▲▼	To Date ▲▼	Units ▲▼	Submitted Charges ▲▼	Approved Amount ▲▼	Claim Status ▲▼
<input type="checkbox"/>	320929910011111001		83036	01/14/2009	01/14/2009	1	\$25.00	\$0.00	Paid
<input type="checkbox"/>	320929910011111002		36416	01/14/2009	01/14/2009	1	\$14.00	\$0.00	Denied
<input type="checkbox"/>	320929910011111003		36415	01/14/2009	01/14/2009	1	\$14.00	\$0.00	Paid

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Add Delete Cancel

Header TCN: [REDACTED]  
 Line TCN: [REDACTED]  
 Beneficiary ID: [REDACTED] Name: [REDACTED]

- Show: ---SELECT---
- SELECT---
  - Claim Cutbacks
  - Claim Enhancement Amounts
  - Claim Header Detail
  - Claim Limit List
  - Claim Notes
  - Codes List
  - Diagnosis Codes
  - Drug Information
  - Indicators
  - Other Payers Information

TCN	Error Description	Erroneous Data
No Records Found !		

Service Line Detail:

TCN: [REDACTED] Claim Type: [REDACTED] Source: Web  
 Adjustment Source: [REDACTED] Bill Type: 0 \* 3 \* 3 \* 7 \* Claim Status: In Process  
 Pricing Rule: [REDACTED]

Beneficiary ID: [REDACTED] Last Name: [REDACTED] First Name: [REDACTED]  
 Gender: Female DOB: [REDACTED] Age: [REDACTED]  
 Benefit Plan: [REDACTED]

Operating Provider ID: [REDACTED] Type: [REDACTED] Taxonomy: 251E00000X  
 Other Provider ID: [REDACTED] Type: [REDACTED]  
 Auth #: [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]  
 Revenue Code: 0551 \* Rate: \$80.98 Modifiers: 1: [REDACTED] 2: [REDACTED]  
 3: [REDACTED] 4: [REDACTED]  
 Manual Units: [REDACTED] Billed Units: [REDACTED] 3 \* Paid Units: [REDACTED]  
 Manual Price: [REDACTED]

Submitted Charges: \$175.00 \* Billed Amount: [REDACTED] Approved Amount: \$0.00  
 Medicare Paid: [REDACTED] Medicare Co-insurance: [REDACTED] Medicare Deductible: [REDACTED]

Previous Next Save Cancel

Header TCN: [REDACTED] Name: [REDACTED]  
 Beneficiary ID: [REDACTED]

Other Payers: Show: --SELECT--

<input type="checkbox"/>	TCN	Payer ID	Claim Filing Indicator	Group	Policy Number	Amount Paid	Responsibility	Quantity	Amount	Adj. Reason Code	
Payer1	[REDACTED]	00953	MB-Medicare Part B		[REDACTED]	\$17.17	P-Primary				
								Adj:	\$0.00	96	
								Adj:	\$3.00	1	
Payer1	[REDACTED]	00953	MB-Medicare Part B		[REDACTED]	\$0.00	P-Primary				
								Adj:	0	\$14.00	2
Payer1	[REDACTED]	00953	MB-Medicare Part B		[REDACTED]	\$3.00	P-Primary				
								Adj:	0	\$11.00	45

Save Delete

Add Payer and Adjustment Details:

Payer	TCN	Payer ID	Claim Filing Indicator	Group	Policy Number	Amount Paid	Responsibility	Quantity	Amount	Adj. Reason Code
NewPayer								Adj:		
ExistPayer										
NewPayer										

Add Cancel



Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED]

Name: [REDACTED]

- Show: ---SELECT---
- SELECT---
  - Claim Cutbacks
  - Claim Enhancement Amounts
  - Claim Header Detail
  - Claim Limit List
  - Claim Notes
  - Codes List
  - Diagnosis Codes
  - Drug Information
  - Indicators
  - Other Payers Information

TCN	Error Description	Erroneous Data
No Records Found !		

Header Details:

TCN: [REDACTED] Claim Type: Z - Home Health  
 Original TCN: [REDACTED] No of Lines: 11  
 Bill Type: 0 \* 3 \* 3 \* 1 \* Medicare: N  
 Adjustment Source: [REDACTED] Pricing Rule: [REDACTED] Commercial: N  
 Claim Status: Paid

Beneficiary ID: [REDACTED] \* Last Name: [REDACTED] First Name: [REDACTED]  
 Gender: M-Male \* DOB: 09/30/1981 \* Age: 27  
 Patient Control Number: 5082 \* Medical Record Number: [REDACTED]  
 Benefit Plan: [REDACTED]

Billing Provider ID: [REDACTED] Type: NPI \* Taxonomy: 251E00000X  
 Operating Provider ID: [REDACTED] Type: [REDACTED]  
 Pay To Provider ID: [REDACTED] Type: [REDACTED]  
 Attending Provider ID: [REDACTED] Type: [REDACTED] Auth #: [REDACTED]  
 Other Provider ID: [REDACTED] Type: [REDACTED] From Date: 03/03/2009 \* To Date: 03/31/2009 \*  
 Total DRG OutLier Payment: [REDACTED] Total APC OutLier Payment: 0 DRG Code: [REDACTED]

Patient Status: 30-Still patient \* Admit Source: [REDACTED] \*  
 Admit Type: [REDACTED] Admit Date: [REDACTED] Admit Hour: [REDACTED] (HH:MM)  
 Discharge Hour: 00:00 (HH:MM) Days Billed: [REDACTED]  
 Principal Diagnosis Code: 3591 \* POA: U-Unknown \* Admitting Diagnosis Code: 3591 Reason For Visit: [REDACTED]  
 E-Code: [REDACTED] POA: [REDACTED] Covered Days: 0 Co Insured Days: 0  
 Other Diagnosis Code: V4611 POA: U-Unknown \* Non Covered Days: 0 LR Days: 0  
 Other Diagnosis Code: V440 POA: U-Unknown \*  
 Manual Price: [REDACTED]

Submitted Charges: \$1,000.00 \* Billed Amount: \$1,000.00 Approved Amount: \$624.58  
 Medicare Paid: [REDACTED] Medicare Co-Insurance: [REDACTED] Medicare Deductible: [REDACTED]  
 Other Insurance: [REDACTED] Other Insurance Co-Insurance/CoPay: [REDACTED] Other Insurance Deductible: [REDACTED]  
 Warrant/EFT Number: [REDACTED] RA Number: [REDACTED] Paid Date: [REDACTED]

Adjust Void Save Cancel

Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED] Name: [REDACTED]  
Show: --SELECT--

Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED] Name: [REDACTED]

Adjust Claim:

Please enter the following information:

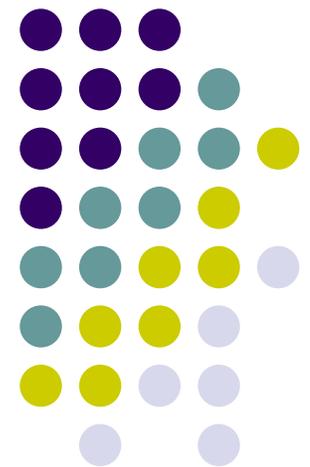
Adjustment Source: PIA-Provider Initiated ADJ \*  
Comment: Enter brief description of changes made here

OK Cancel

# Manage Claims

---

Void Claims





My  
Inbox

Admin

Provider

Claims

Reference

Member

TPL

Rate  
Setting

PA

Contract/MC

Welcome Provider, K. You have logged-in with [redacted] domain and CHAMPS Full Access profile.

Links: --Select--



Path: Provider Portal/ Provider Portal

NPI: [redacted]

Name: [redacted]

Menu

Provider Portal:

Online Services:

Provider [Hide/Max](#)

- [Initiate New Enrollment](#)
- [Manage Provider Information](#)
- [Track Application](#)

Admin [Hide/Max](#)

- [Archived Documents](#)

Claims [Hide/Max](#)

- [Submit Institutional Claim Inquiry](#)
- [Submit Dental](#)
- [Submit Professional](#)

Member [Hide/Max](#)

- [Eligibility Inquiry](#)

Prior Authorization [Hide/Max](#)

- [PA Inquire](#)
- [PA Request List](#)

Welcome!

[Hide/Max](#)



My Reminders:

Filter By: [dropdown] [input] [input]

<input type="checkbox"/>	Alert Type	Alert Message	Alert Date	Due Date	Read
	▲▼	▲▼	▲▼	▲▼	▲▼

No Records Found !



My  
Inbox

Admin

Provider

Claims

Reference

Member

TPL

Rate  
Setting

PA

Contract/MC

Welcome Provider, K. You have logged-in with [redacted] domain and CHAMPS Full Access profile.

Links: --Select--



Path: Provider Portal/ Provider Portal

Menu

Close

Choose an Option:

[Claim Submission](#)

Claim Submission

[Manage Claims](#)

Manage Claims

[Inquire Claims](#)

Inquire Claims

[RA List](#)

RA List



My  
Inbox

Admin

Provider

Claims

Reference

Member

TPL

Rate  
Setting

PA

Contract/MC

Welcome Provider, K. You have logged-in with [redacted] domain and CHAMPS Full Access profile.

Links: --Select--



Path: Provider Portal/ Provider Portal

Menu

Close

Choose an Option:

[Adjust/Void Claim Provider](#)

Adjust/Void Claim Provider





My  
Inbox

Admin

Provider

Claims

Reference

Member

TPL

Rate  
Setting

PA

Contract/MC

Welcome Provider, K. You have logged-in with [redacted] domain and CHAMPS Full Access profile.

Links: --Select--



Path: Provider Portal/ Provider Portal

Menu

Close

Adjust Claims:

TCN:





Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED]

Name: [REDACTED]

- Show: ---SELECT---
- SELECT---
  - Claim Cutbacks
  - Claim Enhancement Amounts
  - Claim Header Detail
  - Claim Limit List
  - Claim Notes
  - Codes List
  - Diagnosis Codes
  - Drug Information
  - Indicators
  - Other Payers Information

TCN	Error Description	Erroneous Data
No Records Found !		

Header Details:

TCN: [REDACTED] Claim Type: Z - Home Health  
 Original TCN: [REDACTED] No of Lines: 11  
 Bill Type: 0 \* 3 \* 3 \* 1 \* Medicare: N  
 Adjustment Source: [REDACTED] Pricing Rule: [REDACTED] Commercial: N  
 Claim Status: Paid

Beneficiary ID: [REDACTED] \* Last Name: [REDACTED] First Name: [REDACTED]  
 Gender: M-Male \* DOB: 09/30/1981 \* Age: 27  
 Patient Control Number: 5082 \* Medical Record Number: [REDACTED]  
 Benefit Plan: [REDACTED]

Billing Provider ID: [REDACTED] Type: NPI \* Taxonomy: 251E00000X  
 Operating Provider ID: [REDACTED] Type: [REDACTED]  
 Pay To Provider ID: [REDACTED] Type: [REDACTED]  
 Attending Provider ID: [REDACTED] Type: [REDACTED]  
 Other Provider ID: [REDACTED] Type: [REDACTED]  
 Total DRG OutLier Payment: [REDACTED] Total APC OutLier Payment: 0  
 Auth #: [REDACTED] Auth #: [REDACTED]  
 From Date: 03/03/2009 \* To Date: 03/31/2009 \*  
 DRG Code: [REDACTED]

Patient Status: 30-Still patient \*  
 Admit Source: [REDACTED] \*  
 Admit Type: [REDACTED]  
 Discharge Hour: 00:00 (HH:MM)  
 Principal Diagnosis Code: 3591 \* POA: U-Unknown \*  
 E-Code: [REDACTED] POA: [REDACTED]  
 Other Diagnosis Code: V4611 POA: U-Unknown \*  
 Other Diagnosis Code: V440 POA: U-Unknown \*  
 Manual Price: [REDACTED]  
 Admit Date: [REDACTED] Admit Hour: [REDACTED] (HH:MM)  
 Days Billed: [REDACTED]  
 Admitting Diagnosis Code: 3591 Reason For Visit: [REDACTED]  
 Covered Days: 0 Co Insured Days: 0  
 Non Covered Days: 0 LR Days: 0

Submitted Charges: \$1,000.00 \* Billed Amount: \$1,000.00 Approved Amount: \$624.58  
 Medicare Paid: [REDACTED] Medicare Co-Insurance: [REDACTED] Medicare Deductible: [REDACTED]  
 Other Insurance: [REDACTED] Other Insurance Co-Insurance/CoPay: [REDACTED] Other Insurance Deductible: [REDACTED]  
 Warrant/EFT Number: [REDACTED] RA Number: [REDACTED] Paid Date: [REDACTED]

Adjust Void Save Cancel



Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED]

Name: [REDACTED]

Show:

--SELECT--



Header TCN: [REDACTED]  
Beneficiary ID: [REDACTED]

Name: [REDACTED]

Void Claim:

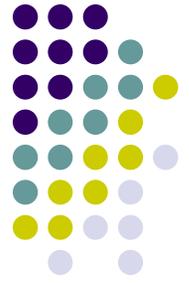
Please enter the following information:

Void Source: PIV-Provider Initiated VOID \*

Comment: Briefly describe why you are voiding this claim.

OK Cancel

# 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...)

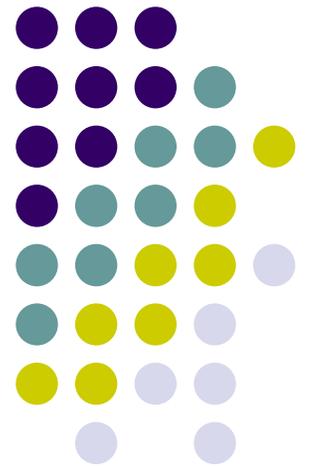
- Adjustment claims- how they are being processed with 117 and 118 bill types?
- CHAMPS creates one claim with TCNxxxxxxx8 (take back/ credited) then another one with TCNxxxxxxx7 (new payment)



TCN ▲▼	Beneficiary ID ▲▼	Billing Provider NPI ▲▼	Claim Type ▲▼	From Date ▲▼	To Date ▲▼	Submitted Charges ▲▼	Claim Status ▲▼
311001110082626000	0012345678	1011223344	F-Outpatient OPPS	01/01/2010	01/01/2010	\$1,569.50	Adjusted
311002170024806000	0012345678	1011223344	F-Outpatient OPPS	01/01/2010	01/01/2010	\$1,645.75	Paid
411002280000212000	0012345678	1011223344	F-Outpatient OPPS	01/01/2010	01/01/2010	\$1,569.50	Credited

# Questions?

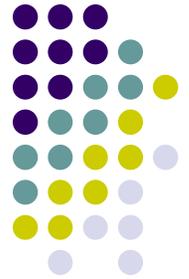
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# Payment Error Rate Measurement PERM



- 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

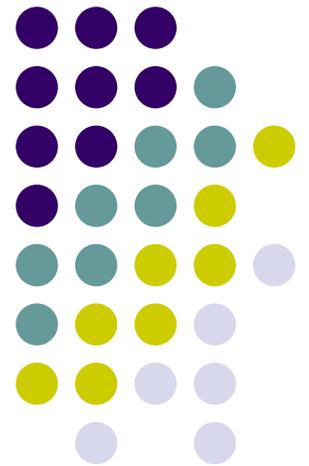


## How Does PERM Work?

- **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

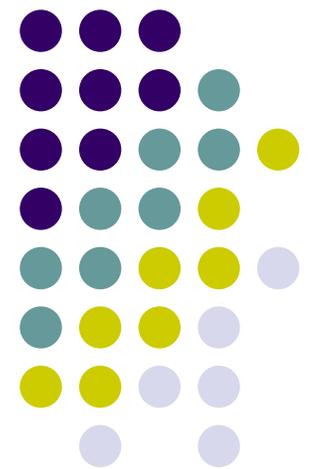
# Questions?

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# Claim Examples

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**Patient Status:** 03-Discharged/transferred to Skilled N \*  
**Admit Source:** 7-Emergency room \*  
**Admit Type:** 1-Emergency  
**Admit Date:** 12/11/2008  
**Discharge Hour:** 11:00 (HH:MM)  
**Admit Hour:** 01:00 (HH:MM)  
**Days Billed:**   
**Principal Diagnosis Code:** 41519 \* **POA:** Y-Yes \*  
**Admitting Diagnosis Code:** 78850  
**Reason For Visit:**   
**E-Code:** E8798 **POA:**   
**Covered Days:**   
**Co Insured Days:**   
**Other Diagnosis Code:** 5856 **POA:** Y-Yes  
**Non Covered Days:** 9  
**LR Days:**   
**Other Diagnosis Code:** 40391 **POA:** Y-Yes  
**Manual Price:**

**Occurrence Codes List:**

Occurrence Code ▲▼	Occurrence Name ▲▼	From Date ▲▼
A3	Benefits Exhausted	07/18/2008
	Add New Line	

**Other Payers:**

Show: | --SELECT-- |

<input type="checkbox"/>	TCN	Payer ID	Claim Filing Indicator	Group	Policy Number	Amount Paid	Responsibility	Quantity	Amount	Adj. Reason Code
Payer1	310933510109998000	999999999	MA-Medicare Part A			\$2,177.18	P-Primary			
								Adj:	\$18,879.08	119
								Adj:	\$8,428.73	45

Part B payment

Cancel

Occurrence Codes List:

Occurrence Code ▲▼	Occurrence Name ▲▼	From Date ▲▼
Add New Line		

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Occurrence Span Codes List:

Occurrence Span Code ▲▼	Occurrence Name ▲▼	From Date ▲▼	To Date ▲▼
71	Prior Stay Dates	12/29/2009	12/30/2009
Add New Line			

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Value Codes List:

Value Code ▲▼	Amount ▲▼	Description ▲▼
Add New Line		

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Condition Codes List:

Condition Code ▲▼	Description ▲▼
39	Private Room Medically Necessary
Add New Line	

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Patient Status:	01-Dischrgd to hm/slf or (rtn) *	Admit Hour:	18:00 (HH:MM)
Admit Source:	7-Emergency room *	Days Billed:	
Admit Type:	1-Emergency	Admitting Diagnosis Code:	78809
Admit Date:	01/03/2010	Covered Days:	4
Discharge Hour:	18:00 (HH:MM)	Non Covered Days:	
Principal Diagnosis Code:	27702 * POA: Y-Yes *	Reason:	
E-Code:	POA:	Co In:	
Other Diagnosis Code:	0417 POA: Y-Yes		

**Patient Status:** 01-Dischrgd to hm/slf or (rtm) \*  
**Admit Source:** 4-Transfer from a Hospital (Different Facility) \*  
**Admit Type:** 2-Urgent  
**Admit Date:** 01/06/2010  
**Discharge Hour:** 13:00 (HH:MM)  
**Principal Diagnosis Code:** 486 \* **POA:** Y-Yes \*  
**E-Code:**  **POA:**   
**Other Diagnosis Code:** 7707 **POA:** Y-Yes  
**Other Diagnosis Code:** V4811 **POA:** 1-Exempt  
**Manual Price:**

**Admit Hour:** 00:00 (HH:MM)  
**Days Billed:**   
**Admitting Diagnosis Code:** 486  
**Covered Days:** 1  
**Non Covered Days:**

**Reason For Visit:**   
**Co Insured Days:**   
**LR Days:**

**Claim Notes:**

Note Type ▲▼	Note ▲▼	Date Entered ▲▼
ADD - Additional Information	CSHCs NO PACE REQUIRED	01/21/2010

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**Refer Claim Notes:**

**Claim Notes:**

Note Type ▲▼	Note ▲▼	Date Entered ▲▼
ADD - Additional Information	CSHCs NO PACE REQUIRED	01/19/2010

Other Payers:

Show:

<input type="checkbox"/>	TCN	Payer ID	Claim Filing Indicator	Group	Policy Number	Amount Paid	Responsibility	Quantity	Amount	Adj. Reason Code
Payer1	311002710010974000	00210	BL-Blue Cross/Blue Shield	GM	83840	\$9,181.39	P-Primary			
								Adj:	\$2,487.68	2
								Adj:	\$4,213.97	45

Cancel

Payer ID through 837 (not DDE)

Primary Insurance

primary payer

Coins amount

write off/contraction amount

Patient Status: 01-Dischrgd to hm/slf or (rt) \*  
 Admit Source: 7-Emergency room \*  
 Admit Type: 1-Emergency  
 Admit Date: 10/03/2009  
 Discharge Hour: 18:00 (HH:MM)  
 Admit Hour: 18:00 (HH:MM)  
 Days Billed:   
 Principal Diagnosis Code: 81201 \* POA: Y-Yes \*  
 Admitting Diagnosis Code: 81201  
 Reason For Visit:   
 E-Code: E8859 POA:   
 Covered Days: 85  
 Co Insured Days:   
 Other Diagnosis Code: 412 POA: 1-Exempt  
 Non Covered Days:   
 LR Days:   
 Other Diagnosis Code: 2830 POA: Y-Yes  
 Manual Price:

Coverd days

Other Payers: Show: ---SELECT---

<input type="checkbox"/>	TCN	Payer ID	Claim Filing Indicator	Group	Policy Number	Amount Paid	Responsibility	Quantity	Amount	Adj. Reason Code
Payer1	310929510036102000	00452	MA-Medicare Part A			\$4,984.61	P-Primary			
									<b>Deduct.</b>	
Primary Insurance- Medicare						Medicare payment		Adj:	\$1,068.00	1
								Adj:	\$10,566.35	45

Billing Provider ID:  Type: NPI   
 Operating Provider ID:  Type: NPI   
 Pay To Provider ID:  Type: NPI   
 Attending Provider ID:  \* Type: NPI  \*  
 Other Provider ID:  Type:

Taxonomy: 282N00000X

Auth #: M909045227

From Date: 03/31/2009 \* To Date: 08/06/2009 \*

Total DRG OutLier Payment: 175481.34 Total APC OutLier Payment: 0 DRG Code: 904

Patient Status: 03-Discharged/transferred to Skilled N  \*  
 Admit Source: 1-Non-Health Care Facility Point of Origin  \*  
 Admit Type: 2-Urgent   
 Admit Date: 01/28/2009  
 Discharge Hour: 15:00 (HH:MM) Admit Hour: 15:00 (HH:MM)  
 Days Billed:   
 Principal Diagnosis Code: 99652 \* POA: Y-Yes  \*  
 Admitting Diagnosis Code: 94108  
 Reason For Visit:   
 E-Code: E8782 POA:  Covered Days: 128   
 Co Insured Days:

Occurrence Span Codes List:

Occurrence Span Code	Occurrence Name	From Date	To Date
71	Prior Stay Dates	01/28/2009	03/13/2009
71	Prior Stay Dates	03/13/2009	03/31/2009
	Add New Line		

Level of Care List:

Filter By: All  Active/Inactive: Active  Go

LOC	Source Provider ID	NPI	CHAMPS Provider ID	Patient Pay	Created Date	Transaction Date	Start Date	End Date
02 - Recipient is receiving Nursing Care services				917	09/24/2009	09/24/2009	08/06/2009	12/31/2999
10 - Recipient authorized for acute care in a general hospital				917	09/24/2009	09/24/2009	07/01/2009	08/05/2009
07 - Recipient enrolled in Medicaid Managed Care				0	09/03/2009	09/24/2009	02/01/2009	06/30/2009

Attending Provider ID: 1011223355 \* Type: NPI \*

Other Provider ID: Type:

Total DRG OutLier Payment: 0

Auth #:

Auth #:

From Date: 11/28/2009 \* To Date: 12/07/2009 \*

Total APC OutLier Payment: 0

DRG Code: 293

Patient Status: 70-Rsvd for ntrnl assignmnt \*

Admit Source: 7-Emergency room \*

Admit Type: 1-Emergency

Admit Date: 11/28/2009

Discharge Hour: 17:00 (HH:MM)

Admit Hour: 15:00 (HH:MM)

Days Billed:

Admitting Diagnosis Code: 78805

Reason For Visit:

Principal Diagnosis Code: 42823 \* POA: Y-Yes \*

E-Code: POA:

Covered Days: 9

Co Insured Days:

Other Diagnosis Code: 25040 POA: Y-Yes

Non Covered Days:

LR Days: 9

Other Diagnosis Code: 2948 POA: Y-Yes

Other Payers:

Show: --SELECT--

	TCN	Payer ID	Claim Filing Indicator	Group	Policy Number	Amount Paid	Responsibility	Quantity	Amount	Adj. Reason Code
Payer1	310938410005804000	00452	MA-Medicare Part A			\$1,257.98	P-Primary			
								Adj:	\$4,808.00	2
								Adj:	\$16,734.24	45

Cancel

Other Provider ID:  Type:

From Date: 01/30/2010 \* To Date: 02/04/2010 \*

Total DRG OutLier Payment: 0 Total APC OutLier Payment: 0 DRG Code: 190

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Patient Status: 01-Dschrgd to hm/slf or (rtn) \*

Admit Source: 7-Emergency room \*

Admit Type: 1-Emergency

Admit Date: 01/30/2010 Admit Hour: 09:00 (HH:MM)

Discharge Hour: 18:00 (HH:MM) Days Billed:

Principal Diagnosis Code: 49121 \* POA: Y-Yes \* Admitting Diagnosis Code: 49121 Reason For Visit:

E-Code:  POA:  Covered Days: 5 Co Insured Days: 5

Other Diagnosis Code: 42833 POA: Y-Yes Non Covered Days:  LR Days:

Other Diagnosis Code: 5849 POA: N-No

Other Payers:  Show:

<input type="checkbox"/>	TCN	Payer ID	Claim Filing Indicator	Group	Policy Number	Amount Paid	Responsibility	Quantity	Amount	Adj. Reason Code
Payer1	311006210120128000	00452	MA-Medicare Part A			\$9,212.29	P-Primary			
								Adj:	\$1,375.00	2
								Adj:	\$18,374.69	45

# Questions?

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

