

PROVIDER INQUIRER

January 1st, 2007

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Update on Michigan Medicaid Hospital Audits

The Michigan Department of Community Health Program Investigation Section and our Contractor MPRO have completed several years of Hospital Inpatient and Outpatient Audits. MPRO has observed similarities in incorrect billing among hospital providers.

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For Inpatient Hospital Audits Provider Type 30:

- 1) Missing documentation results whether it is scanned at the facility or the provider submits the medical record to MPRO; thus impeding a thorough review and may result in funds being recovered.
- 2) Many providers are not obtaining prior authorization numbers (PACER authorization) for re-admissions within 15 days or transfers, resulting in a denial and funds recovered.

For Outpatient Hospital Audits Provider Type 40:

- 1) Providers have tended to use Revenue Code 250 to include all pharmacy billing, but it is only applicable if non-injectables are given to the patient.
- 2) Providers assign a Revenue Center Code 710-recovery room or Revenue Center Code 360-operating room when a patient has undergone an endoscopy procedure. The provider should bill Revenue Center Code 750-gastro intestinal services. This code includes the endoscopy procedure, the room, and the recovery room.
- 3) Providers should bill the operating room by one-half hour increments as needed for the procedure provided to the beneficiary. Providers frequently bill the actual time spent in the operating room, rather than the correct method of billing by one-half hour increments.

- 4) Providers frequently list quantities of medications given incorrectly when required for billing purposes.

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5) Providers often bill for false labor, Revenue Code 729, when a patient is undergoing a non-fetal stress test, and there are no indications of contractions or active labor. The provider should bill only for the stress test, Revenue Code 920, with CPT code 59025.

MPRO has attempted to use the appeal setting to educate providers; however these issues need to be communicated to all Michigan Medicaid Hospital Providers for educational purposes.

The State of Michigan Offices will be closed:

Monday, January 1, 2007

Tuesday, January 2, 2007

Monday, January 15, 2007

New Paper Claim Formats

Bulletin MSA 06-73, which was issued on October 16, 2006, announced the implementation schedule for the new paper claims formats. There have been many questions about the changes to the new CMS 1500 (08/05).

MDCH is currently finalizing the specs to implement the new CMS 1500 (08/05) claim form with an implementation date planned for April 1, 2007. A future bulletin will be published to providers with special claim completion instructions specific to meet the claim processing needs for MDCH in addition to following the NUCC instructions.

Providers need to be aware that the new CMS 1500 (08/05) does not allow providers to report the Coordination of Benefit (COB) codes. The COB codes are currently used on the professional paper claim to report other insurance information.

Providers that are still using paper claims for secondary/tertiary claims need to contact their billing agents to find out why they are not submitting secondary claims electronically. Michigan Medicaid can accept secondary/tertiary claims electronically.

Any billing agents that would like to complete testing for secondary claims should view the website at www.michigan.gov/medicaidproviders >> Electronic Billing, or contact AutomatedBilling@michigan.gov.

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NPI Countdown Column



Less than 100 Business Days before MAY 23, 2007! Do you have your NPI???

Medicaid has scheduled NPI testing for electronic claims to begin in January 2007. CMS has identified a common testing error among those submitting electronic claims; billers are submitting an NPI in the 2010AA Billing Provider REF02 segment instead of the NM109. The reference segment is situational, but is required if it is necessary to report a secondary ID, such as a legacy ID and an EIN/TIN. NM109 is where the NPI is to be submitted, but billers have been placing the legacy ID there instead.

Please make sure when submitting claims to include your legacy Medicaid Provider ID number along with your NPI number so your claim can be properly adjudicated. MDCH is currently accepting NPI numbers on Professional and Dental claims but adjudicating off of the legacy Provider ID number.

MDCH has received many questions about the new claim forms coming out in 2007 that were referenced in the Bulletin MSA 06-73. MDCH is currently finalizing the specs to implement the new CMS 1500 (08/05) claim form with an implementation date planned for April 1, 2007. A bulletin with a proposed release

date of February 1, 2007, will be published to providers with special claim completion instructions specific to meet the claim processing needs for MDCH in addition to following the NUCC instructions.

If you have not already applied for an NPI number, please do so soon. It is important that you report your NPI numbers to Medicaid as soon as possible. Without your NPI numbers on file, Medicaid may not be able to crosswalk your claims back to your Medicaid Provider ID number, which could cause a potential lapse in payment.

You can apply for your NPI with NPPES online at <https://nppes.cms.hhs.gov/> or call toll free at 1-800-465-3203. You may also contact NPPES for NPI questions regarding the status of an application, forgotten or lost NPI numbers, lost NPI notification letters, trouble accessing NPPES, forgotten NPPES password/user ID or if you need to request a NPI paper application.

Any questions may be directed to the Provider Inquiry Unit at 1-800-292-2550 or you can email your NPI questions to npi@michigan.gov.

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THE CORNER

Community Health Automated Medicaid Processing System

Provider Input and Suggestions

In an effort to make CHAMPS as efficient and user friendly as possible, the Michigan Department of Community Health (MDCH) is re-evaluating the timeframe for implementing the various stages of the CHAMPS project.

For updates on the CHAMPS project please log on to www.michigan.gov/mdch and click on the CHAMPS logo on the left side of the home page.

Provider input is vital to the development of CHAMPS. CHAMPS development teams are soliciting provider feedback for each step of the project. If you have any suggestions on the web re-design, provider enrollment or claims processing, please send those comments to Champs@michigan.gov. MDCH wants to know what you think. If you have a topic that you would like discussed in "The CHAMPS Corner", please let us know.

The purpose of the Champs@michigan.gov email address is for the development team to collect provider input regarding the development of CHAMPS; therefore providers will not receive a response unless clarification is needed.

Providers are encouraged to continue submitting their billing related inquiries to the Provider Inquiry Unit at ProviderSupport@michigan.gov or 1-800-292-2550.

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Dental Claim Replacements and Void/Cancel Claims

Dental claims that have paid incorrectly and therefore need to have money and/or services corrected must be resubmitted as Replacement Claims. Claims that must be completely removed from the system and not replaced must be resubmitted as Void/Cancel Claims. Replacement and Void/Cancel Claims can be sent electronically or on paper. MDCH always recommends billing electronically and using a billing-agent/service-bureau that can satisfy all of HIPAA and MDCH's electronic billing requirements. Paper Replacement and Void/Cancel Claims (ADA 2002/2004) must satisfy all paper claim completion requirements and be sent to the following address:

Research and Analysis
Dental Replacement/Void
P.O. Box 30731
Lansing, MI 48909

These claims will be submitted by the DCH staff and will appear on a future remittance advice in about 2-4 weeks, with a 584 edit code.

A **CLAIM REPLACEMENT** claim should be completed to replace or adjust money and/or services paid incorrectly. An example would be if a service paid with \$0.00 with an incorrect amount, procedure code reported wrong or an error in the tooth letter/number. An ADA 2002/2004 claim form needs to be completed with the information that would have been billed for correct payment. Provider Type and ID#, Beneficiary ID# should remain as it appears on the original claim. Place in the remarks section (35) the 10 digit Claim Reference Number, from the paid claim, with the words Replacement Claim. This should appear as "CRN: 0123456789 Replacement Claim". Remember all services even if paid must be on the claim to retain payment of original paid services.

A **VOID/CANCEL** claim will remove a claim from the system. A claim may need to be voided from the system if services have been billed using the wrong provider and/or beneficiary ID#. For example this could happen if more than one family member is seen on the same day of services and beneficiary ID numbers are switched. Another example would be if a beneficiary wishes to return dentures and go to a different provider. A claim must be filled out on a paper ADA 2002/2004 claim form and mailed to the above address. Only 1 service line is necessary on a Void /Cancel claim. No money should be reported on the voided claim. In the remarks section (35), the 10 digit Claim Reference Number from the paid claim and the words Void/Cancel must appear. This should be reflected as "CRN: 0123456789 Void/Cancel"