STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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GOVERNOR

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Dear CMH Provider:

This letter transmits information for Community Mental Health providers that received inappropriate payments from the Michigan Department of Community Health (MDCH) for Medicare/Medicaid dually eligible beneficiaries.

Enclosed with this letter is a document titled "Void Claim Request File Process for CMH Crossover Claims." It provides a brief explanation of the cause of the inappropriate payments and the process for returning monies to MDCH. Also enclosed are answers to frequently asked questions related to the process.

MDCH regrets it cannot alleviate the problem of inappropriate payments to CMHs for Medicare crossover claims until it implements the new CHAMPS claims processing system. In the interim, the understanding and cooperation of the CMHs with the process described is appreciated.

Questions related to this issue should be directed to ProviderConsultant@michigan.gov c/o Stephen Kuncaitis.

Sincerely,

Paul Reinhart, Director
Medical Services Administration

enclosures

Void Claim Request File Process for CMH Crossover Claims

Overview

The process described below has been created to facilitate the return of inappropriate fee-for-service (FFS) Medicaid payments made to CMH providers as a result of Medicare claim crossovers and NPI implementation. The payments are for services included in the CMH capitation plan. The process may also be used for claims approved with zero payment (because Medicare's payment was greater than MDCH fee schedule) to correct overall reporting. Claims approved (Source/Status on any claim line is anything but "PEND" or "REJ") with a total balance of zero dollars are also considered paid and the approved services are included in Federal Reporting so should also be corrected through the void process.

CMH providers must identify claims by Claim Reference Number (CRN) that they wish to void in order to return inappropriate payments to MDCH or correct approved claim data. The list of CRNs to be voided must be sent to MDCH in an electronic file (see File Format below). MDCH will test the file for errors and resolve (remove or fix) errors with the provider prior to voiding claims. Testing of a file will take an estimated two weeks.

Voided claims will appear as negative payments on the provider's MSA Remittance Advice an estimated two weeks after errors have been resolved. The total minimum time from submission of a Void Claim Request (CRN void file) to voiding the claims is 4-6 weeks (subject to change).

CMHs may submit only one Void Claim Request per tax ID between now and August 31, 2008. A second request may be submitted during a period more closely preceding the release of the CHAMPS Claims System. The second request period will be dependent on the progress of the CHAMPS Claims System development and therefore will be determined at a later date.

CMH Responsibilities

The organization submitting the Void Claim Request (CRN void file) is responsible for ensuring the CRNs are correct. The person who submits the Void Claim Request must have proper authorization to void the claims (as determined by the CMH). Because MDCH will void all claims identified in the CRN void file, the submitting provider is responsible for initiating resubmission of any claims voided in error.

MDCH cannot submit new/original claims for claims voided in error, nor can it submit replacement claims if a voided claim contained services paid appropriately along with services paid inappropriately.

> **Example:** There are four services on the claim forwarded by Medicare to MDCH. One service is rejected by MDCH and three services are approved by MDCH, each with amounts greater than zero dollars. Two of the three services are capitated services. One of the three approved services is a FFS injectable. Provider needs to return payment for the two capitated services but maintain the injectable as an appropriate FFS payment. Provider has two options:
>
> 1. Include the claims on the void list. After the entire claim is voided, provider must resubmit the claim directly to MDCH as an original secondary/tertiary claim with only the appropriate service(s).
> 2. Do not include the claims on the void list. Instead, submit a replacement secondary/tertiary claim with only the appropriate service(s), including all of the primary payer information (and secondary payer information if secondary payer is other than Medicaid) directly to MDCH. This process is outlined in the Billing & Reimbursement for Professionals Chapter of the Michigan Medicaid Provider Manual available online at www.michigan.gov/medicaidproviders.

Providers should not submit replacement claims on paper, if at all possible.

File Format

Providers must submit their list of CRNs as either a text file (.txt) or excel (.xls) file saved under the name of the organization followed by the tax ID (example: AntarcticaCMH380000000.xls) with one column containing the CRN of the claim(s) they would like to void - one CRN per line/row/record, no duplicate CRNs on multiple lines. A header row must read "CRNs under [Tax ID]". [Tax ID] should be the 9-digit Tax ID Number (i.e. 000000000) that all of the CRNs were paid under. The CRN should be formatted as a numeric 15 character field with two-zero-

zero ("200") always leading and two zeros ("00") always following the 10 digit CRN that appears on the remittance advice:

CRNs under 000000000
200**800100000100**
200**736799999900**
200**700100000100**

(Bolded is CRN as it appeared on remittance when paid – do not apply bold font to your file, bolded here only for reference)

Submitting a Void Claim Request

Void Claim Request must be emailed to ProviderConsultant@michigan.gov with the CRN void file attached. The subject line of the email should indicate "CMH Void Claim Request" and the name of the requesting organization. The body of the email must include:

- "Attn: CMH Void Claim Request (C/O Stephen Kuncaitis)"
- Submitter's name, organization, phone, email, fax, and mailing address
- a statement from the submitter indicating that they intend and approve voiding of the CRNs in the attached file
- a copy of this document as an attachment to verify that the submitter has read and understands the instructions.

All questions about this process should be directed through the Provider Consultant email address above.

Recovery of MDCH Inappropriate Payments

Providers must not submit a check for these inappropriate payments. Any debt created by the void claim process will be deducted from future approved FFS payments from the same program fund, identified as the "Source/Status" column on paper MSA Remittance Advice, as a negative payment.

> **Example:** If the original claim and negative/void claim have a Source/Status of **MA** then the negative amount will *first appear* on the provider's MSA Remittance Advice (RA) summary page as "**Balance Owed by Provider to MDCH**" and on future remittance's summary pages as "**Previous balance owed by provider**" until claims with an equal or greater amount have been approved with a Source/Status of **MA**; claims approved under any other Source/Status, like **CW**, may still generate a check rather than deduct the debt.

Provider billing IDs without sufficient future payments to return all money through this debt process (i.e. no longer enrolled or no longer providing services under the program fund – MA or CW – of the outstanding debt) will need to call Provider Support at 800-292-2550 after all voids are completed (meaning all CRNs provider requested have appeared as negative amounts on remittances from MDCH) to pursue reconciling the balance. The reconciliation will only be executed once to clear a balance for a provider billing ID so it is very important to wait until all claims for the provider billing ID have voided.

A separate file of CRNs should be submitted for each tax ID involved. MDCH will accept CRNs up to two years old. The Julian Date imbedded in the beginning of the CRN should be used to calculate the two year cut-off.

> **Example:** 7124 at the beginning of a CRN indicates that the claim was received by MDCH on the 124th day of the year 2007 which is May 4, 2007.

FREQUENTLY ASKED QUESTIONS

CMH Return of Inappropriate Payment

This document addresses frequently asked questions related to the process developed by the Michigan Department of Community Health for Community Mental Health providers to return inappropriate payments resulting from Medicare cross-over claims.

Q. I only started receiving these payments in October with the beginning of NPI. Do I need to look at my closed records for the previous two years?

A. Participation is not required. It is expected that providers will include all CRNs that have already been identified as inappropriate payments. The extent of a provider's participation is at the provider's discretion.

Q. I know I received erroneous payments but I was told by DCH to keep the payments and our books are closed for previous fiscal years. Do I need to research these claims and send in a void request?

A. Providers are not required to participate in this process, the extent of a provider's participation is at their discretion. MDCH may attempt to recover these inappropriate payments at a future date, but no specific plans have been made.

Q. Why can't the tax ID of the provider be used to identify and eliminate the crossover payments of capitated services? The state certainly has on record the tax ID of the agencies receiving capitated payments. The Type 10 ID numbers associated with the CMHs would be using the same tax ID for payment.

A. MDCH is considering the safest way to do this without disturbing the other provider payments.

Q. This is especially frustrating when the incorrect payments continue to be issued with no end in sight. How will CHAMPS fix this problem?

A. Though providers are required to submit NPI on their claims, the current MDCH claims processing system crosswalks the NPI back to the old Medicaid provider type and ID number to adjudicate claims. Limitations to the crosswalk logic are causing the incorrect payments. Since CHAMPS is an NPI-based system, the crosswalk will not be necessary.

Q. Do I have to submit a different file for each rendering provider?

A. No. The file submitted between now and August 31st should include all providers under a single tax ID.