MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Distribution: All Providers

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Subject: Community Health Automated Medicaid Processing System (CHAMPS) Implementation Update

Effective: As Indicated

Programs Affected: Medicaid, Adult Benefits Waiver (ABW), Children's Special Health Care Services (CSHCS), Children's Waiver, Children's Serious Emotional Disturbance Waiver (SED), Maternity Outpatient Medical Services (MOMS), Plan First!, and other Health Care Programs Administered by Michigan Department of Community Health

The Michigan Department of Community Health (MDCH) is in the process of replacing its current Medicaid claims processing system with a new system called CHAMPS. In March 2008, MDCH launched the Provider Enrollment (PE) Subsystem of CHAMPS. Effective September 18, 2009, MDCH will implement the Eligibility, Prior Authorization (PA), Claims and Encounters (CE), and Contracts Management Subsystems. Within the CE Subsystem, Fee-for-Service (FFS) claims submitted on and after September 18, 2009, will be processed for payment starting on October 1, 2009. The purpose of this bulletin is to inform both FFS and Medicaid Health Plan providers of the changes scheduled for implementation. This bulletin provides information regarding the following:

1. CHAMPS PE Online Subsystem Clarification
2. Business-To-Business (B2B) Testing for Billing Agents
3. Implementation of CHAMPS Eligibility Subsystem
4. Implementation of CHAMPS PA Subsystem
5. Implementation of CHAMPS CE Subsystem
6. Contracts Management Subsystem

1. CHAMPS PE Online Subsystem

Establishment of Provider Domains and Provider Profiles

To access the CHAMPS system, providers must log onto https://sso.state.mi.us to register for their Single Sign-On (SSO) user identification (ID) and password. All users within a provider's organization who will need access to information within CHAMPS (PE, Claims, PA, etc.) must obtain a SSO user ID and password. The CHAMPS PE Online Subsystem allows providers to easily update their information at any time or submit a new provider enrollment application with an anticipated approval process of only one to two weeks.

MDCH recommends that all organizations maintain a list of each user's ID. The SSO user who submits the domain application (which subsequently becomes approved) will become the Provider Domain Administrator for that application. The Provider Domain Administrator will have responsibility of assigning rights for all other users within the organization to access the provider's file. If necessary, multiple Provider Domain Administrators may be established for a single organization but a separate application must be completed and approved for each administrator. For more details related to establishing domain security rights, please refer to the MDCH website at www.michigan.gov/medicaidproviders >> CHAMPS >> SSO/DomainWebinar.

In addition to the establishment of a provider domain and obtaining necessary user IDs and passwords, the provider must select the appropriate profiles to access applicable subsystems within CHAMPS. The following table lists the available profiles for each type of provider accessing the system.

Table 1 – CHAMPS Provider Profiles

Provider Profiles Available for Providers:	Domain Administrator	CHAMPS Full Access	CHAMPS Limited Access	Prior Authorization Access	MCO Provider Access	Eligibility Inquiry	Provider Enrollment Access	Provider Enrollment View Access	Claims Access
FFS Provider	X	X	X	X		X	X	X	X
MCO Provider	X		X		X	X		X	X
Billing Agent	X						X	X	X
Pharmacy	X					X			

Billing agents in CHAMPS will also have access to the Eligibility Inquiry Profile if they are associated with a provider that allows them to access on their behalf. The provider must first associate themselves with a billing agent before this functionality will be made available.

2. B2B Testing for Billing Agents

MDCH is developing a process to conduct CHAMPS testing with billing agents prior to implementation. To assure continued confidence for accurate information exchange with MDCH registered billing agents, the Program recommends that the B2B testing process be conducted to validate the delivery of data within CHAMPS.

The MDCH testing team is currently conducting extensive testing on inbound files within the parallel testing environment by comparing FFS claim adjudication within the current Medicaid claims processing (legacy) system to the new CHAMPS system. As a phase-in approach to B2B testing, the next step will include the review of outbound files from CHAMPS to select MDCH registered billing agents. Within the next few weeks, a sample set of MDCH registered billing agents will be chosen to validate technical interfaces and basic file structure components. This testing process will be followed by a larger segment of partners to test the complete set of possible transaction types. During the final stage of B2B testing, a sample file will be made available to each billing agent to utilize in validating their system's ability to access and interchange transactions within CHAMPS. In most cases, the files will duplicate the processes and structures that are currently in place with MDCH. A follow-up communication with the technical specifications will be communicated to the billing agent prior to their testing window.

MDCH encourages all registered billing agents to take advantage of this testing process. To further assist providers with this transition, a new communication model will be introduced which is referred to as a "relationship owner." The role of the relationship owner is to assist the billing agent during CHAMPS Pre-Go Live with file exchange and to resolve any issues that may be produced by the new application. An important focus of the CHAMPS project is to ensure that vital services to providers will continue to function smoothly throughout implementation.

3. CHAMPS Eligibility Subsystem

Effective September 18, 2009, the CHAMPS Eligibility Subsystem will offer providers two options for beneficiary (member) eligibility inquiries. These options include online eligibility information through the CHAMPS provider portal and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 270/271 transaction format for batch requests through the MDCH Data Exchange Gateway (DEG).

The eligibility response for these options will contain benefit plan data for the date of service, which is assigned by the Eligibility Subsystem based on the source of the data (e.g., Medicaid, CSHCS, and MOMS) and program assignment factors (e.g., scope/coverage codes, Level of Care [LOC] codes, etc.). Providers will need to utilize the Benefit Plan ID(s) indicated in the response to determine a beneficiary's program coverage and related

covered services for a specific date of service. A complete listing of Benefit Plan IDs and their descriptions will be shared in the future.

The eligibility response may also contain the following information:

- LOC information (including the LOC code), Source Provider ID (supplied through the Department of Human Services[DHS]), National Provider Identifier (NPI), provider name, telephone number, address, and patient pay amount, if applicable.
- Medicaid Health Plan (MHP) Primary Care Physician (PCP), including the PCP name, telephone number, and NPI. (Note: Data provided only if the date of service is the current date.)
- Third-Party Liability (TPL), including the payer name, payer ID, coverage type code, group number, policy number, and policy holder ID.
- CSHCS restriction data, including qualifying diagnosis code(s) and authorized provider list if the provider submitting the inquiry is authorized for the date of service.
- Other information: Transaction date (when the data was applied to the Eligibility Subsystem), current county of residence, DHS case number, DHS worker load number, and DHS local office home number.
- Pending Eligibility (Medicaid-related programs only): Providers will have the option to see if eligibility is pending.

After the release of the CHAMPS Eligibility Subsystem, existing eligibility verifications systems (e.g., Automated Voice Response System [AVRS] and web-Denis) will continue to be available. The response information for these systems will be provided directly from the Eligibility Subsystem.

4. CHAMPS PA Subsystem

Effective September 18, 2009, the PA Subsystem will allow providers to submit single PA requests through the online web portal in addition to the existing HIPAA X12 4010A1 278 batch transaction format and paper PA process. PA Inquiry is also a new feature available through CHAMPS that will allow providers to check on the status of submitted PA requests.

The paper PA copy of the review resolution (e.g., Approval, Denial, No Action) that is currently sent to all providers will end with the implementation of the CHAMPS PA Subsystem. Instead, the review results of the PA request will be provided within a letter (e.g., Notice of Authorization), which will include its resolution, procedure code(s), description, quantity and fee rate, PA start and end dates, and PA number. A separate letter will be generated for each PA request regardless of the mode of submission and will be viewable in the system.

<u>PA Direct-Data Entry (DDE) Requests</u>

The PA Subsystem will allow providers to submit PA requests directly online through DDE by accessing the “PA Request List” web portal. CHAMPS will validate both the beneficiary and provider information. An error message will be returned to the user if the information is incorrect. Any provider may request a PA, but the provider NPI entered in the servicing provider field must represent the provider who will be rendering the service.

Providers may need to provide additional information as required by the HIPAA 278 transaction but not currently part of the PA paper format, before the CHAMPS system will allow the PA to be submitted. For example, vision providers will be required to report diagnosis codes as a mandatory field. Other examples of new fields include service type code, facility code qualifier, and certification type.

Once the PA is successfully entered, the provider will receive a tracking number. After the request is approved by MDCH, the same tracking number will become the PA authorization number to use for billing purposes. The PA number will not be valid for claims until the PA request is approved. Modifications to existing prior authorizations on file can be requested through the Program Review Division as is currently done.

The cancel button will allow the user to void a PA request before the request is submitted. Once cancelled, the information entered is not saved.

Submitting Documentation for DDE PA Requests

Supporting documentation for DDE PA requests may be submitted by fax or electronically. The electronic system will limit each PA request to 10 document attachments and each attachment has a maximum size of 100MB. There is no maximum number of pages for faxed documents.

PA Inquiry

The PA Inquiry web portal within the PA Subsystem allows the user to query PAs submitted by the requestor by entering a specific tracking number. Current PA status can also be seen on the PA Request List screen. Information includes the beneficiary ID number, authorization status (e.g., Entering, Requested, Approved, Returned) and service start and end dates.

5. CHAMPS CE Subsystem

Effective September 18, 2009, the CE Subsystem will allow FFS claims submission, inquiry, and adjustments/voids through the CHAMPS online system. FFS claims submitted on and after September 18, 2009, will be processed for payment starting on October 1, 2009. The ability for Managed Care Organizations (MCOs) to submit encounter claims through CHAMPS will not be implemented until the next CHAMPS phased release. MCOs will continue to submit encounter claims via the legacy system until further notice.

FFS providers may submit claims directly online through a batch upload process or through DDE. Also providers may view claims within the subsystem and complete online claim replacements. However, rendering/servicing providers do not have access to submit claims, claims adjustments or void/cancel claims through CHAMPS. Claims must be submitted by the billing provider.

Additional changes include the new 18-digit Transaction Control Number (TCN). The TCN will replace the existing 10-digit Claim Reference Number (CRN) used for adjudicated claims within the legacy system. Also, MDCH proprietary edits and explanation codes will no longer be used for claim adjudication. Providers must instead refer to the HIPAA-compliant Claim Adjustment Reason Codes (CARCs) and Remittance Advice Reason Codes (RARCs), which will be available through the claim inquiry process or included with the Remittance Advice (RA).

FFS Claim Submission through CHAMPS

Three main options will be available to providers for submitting claims electronically to MDCH once the FFS Claim System for CHAMPS is implemented:

A. Batch submission of claims via the MDCH DEG

Providers may submit claims to the DEG by contracting with an MDCH-authorized billing agent or by becoming a billing agent. This option allows the submission of thousands of claims at a time and is primarily used by billing agents. A list of MDCH-authorized billing agents is available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Electronic Billing >> How to Become an E-Biller (under Michigan Medicaid Approved Billing Agents). These billing agents are authorized to submit both primary and secondary Medicaid claims. MDCH does not recommend any billing agent over another.

Providers who bill large volumes of Medicaid claims and wish to submit claims directly through the DEG rather than contracting with a billing agent must be authorized by MDCH as an electronic billing agent. Providers wishing to submit their own claims through the DEG are required to enroll as a billing agent in CHAMPS.

B. Direct Electronic Batch Upload

CHAMPS will provide the option of uploading batches of claims directly without going through the DEG. With the limit on the file size, this option is suitable only for providers with lower volumes of claims. Providers interested in choosing this function must be able to create HIPAA compliant 837 files in a specified .dat file format. The "Electronic Batch" mode of claims submission must be selected in the provider enrollment record. Contact the MDCH Automated Billing Unit at AutomatedBilling@michigan.gov for additional information on Electronic Batch claim submission.

C. Submission of Claims Individually via CHAMPS DDE

A new DDE option will be available on the CHAMPS web portal. This will allow providers to key the claim information directly on a screen that looks similar to the paper claim formats. There will be built in checks on certain fields, such as diagnosis and procedure codes, to verify that these codes are valid and formatted correctly. This option is well suited to providers who have low claim volume and do not wish to develop a technical solution or hire a billing agent. Providers must have a CHAMPS SSO user ID and password and log on with their billing provider NPI. The "Online Direct Data Entry" mode of claims submission must be selected in the provider's enrollment record. Additional information and instructions on how to use CHAMPS DDE will be shared in the near future.

Submitting Documentation for Electronic Claims

In order to submit supporting documentation for electronic claims, billers must register to use Documentation EZ Link. Documentation EZ Link is a no-cost service which allows billers to submit documentation by fax or electronically through a secure web portal. Information on registration, technical requirements, and user training is available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Documentation EZ Link.

Manage Claims – Adjustments and Voids

The Manage Claims web portal within the CE Subsystem will allow providers to either adjust or void/cancel claims online. Adjudicated claims within the legacy system will be converted into CHAMPS with a 15-digit number. When adjusting claims, providers will have the option to enter modifications to data elements of the paid claim. Elements derived through claim processing, pricing, and/or certain submitted fields (e.g. Billing and Pay-To NPI, Beneficiary ID) cannot be changed. Once a provider enters select changes to modifiable data elements and clicks the "adjust button", the replacement claim header will create an 18 digit CHAMPS TCN. It is recommended that the provider print this information for their records. When canceling/voiding a claim, no data will be editable to the user.

Changes to Accounts Receivables

The MDCH accounting process for handling accounts receivables will change in CHAMPS. Currently, if a provider tax ID number has an outstanding receivable (e.g., void/claim adjustment or MDCH-initiated gross adjustment), the system will offset the amount against payments for the same provider ID number within the same transaction type.

For CHAMPS, an outstanding receivable for a provider tax ID number will be offset against payments for the same NPI, if possible, and then against other provider NPIs with the same tax ID. In addition, the system will offset the amount from the same transaction type first. If insufficient funds still exist, the system will then refer to other applicable transaction types until the entire amount has been rectified.

Claims Inquiry

CHAMPS will offer providers two options for claim inquiries. The HIPAA 276/277 format will allow batch requests through the MDCH DEG. The Inquire Claims web portal within the CE Subsystem connects the user with multiple filter options when submitting a claim query online. Providers can only inquiry on claims submitted by the billing NPI logged into the system. Multiple filter values may be used when submitting a claim inquiry. The TCN, beneficiary ID number, and claim status are examples of the available filter values.

For a “pended” claim status, HIPAA Claim Status and Category codes will be listed. “Paid” claims will list the HIPAA CARCs and RARCs.

CHAMPS Remittance Advice (RA)

A RA will be generated for all providers and/or billing agents in which claims were submitted and processed through CHAMPS on and after the first payment date of October 1, 2009. The new CHAMPS RA will be available to providers online or will be sent to providers via paper only if requested through the PE Subsystem. The unsolicited submission of the paper RA to all providers will end with the implementation of the CE Subsystem and instead will be available online based on the weekly pay cycle.

The RA generated through CHAMPS will contain new elements. A few of the existing elements available in the legacy paper RA will be removed as well to more closely comply with the electronic HIPAA compliant 835 format. The following lists represent these changes.

New Elements on the RA in CHAMPS

- Billing Provider NPI – 10-digit NPI identifying the entity requesting payment
- Remittance Advice Number – Each 835 will be assigned a RA Number that will be added to the paper RA
- Gross Adjustment Information – Details related to a gross adjustment (e.g., Adjustment Type, Previous Balance, Adjustment Amount, Remaining Balance)
- Warrant/Electronic Fund Transfer Number – Number on the Warrant from Treasury
- Warrant/Electronic Fund Transfer Date – Date on the Warrant from Treasury
- Gross Adjustment ID – Number that identifies the Gross Adjustment in CHAMPS
- Medical Record Number – Number that was submitted on the claim
- Type of Bill – Three digit code (837 Institutional) that details the type of facility services rendered
- Rendering Provider NPI – 10 digit NPI identifying the individual providing the service
- Modifiers (all) – All modifiers reported within the 837 transaction or up to four modifiers within the paper claim formats will be returned on the RA
- Health Insurance Prospective Payment System (HIPPS) Rate Codes (837 Institutional) - Represent specific sets of patient characteristics in which payment determinations are made in the Prospective Payment System
- Diagnosis Related Groups (DRGs) – (837 Institutional) - Assigned by a "grouper" program based on diagnoses, procedures, age, gender, discharge status, and the presence of complications or comorbidites
- Ambulatory Payment Classification (APC) - Used within the hospital outpatient payment system in which hospitals receive a fixed payment for a specific procedure
- Category – Used to categorize the status of the submitted claim (e.g., Paid, Suspended, Rejected, etc.)
- Claim Adjustment Reason Codes (CARCs) – Communicate why a claim line or service line was paid differently than was billed
- Remittance Advice Remark Codes (RARCs) - Relay service line information that cannot be communicated by the CARC

Elements Discontinued for the RA in CHAMPS

- Legacy Provider ID and Type – Eliminated due to the implementation of the NPI
- Total Amounts of Paid/Suspended/Rejected claims - No longer accurately reflects reporting amount due to the implementation of Claim Adjustment Segments (CAS) codes
- Pay Source Summary – No longer applicable in CHAMPS
- Diagnosis Code – Not compliant based on electronic HIPAA compliant 835 Transaction
- Tooth Number/Surface/Area of Oral Cavity – Not compliant based on electronic HIPAA compliant 835 Transaction
- Source/Status – No longer applicable in CHAMPS
- Legacy Explanation Codes – Not compliant based on electronic HIPAA compliant 835 Transaction (Reason/Remark codes will be used instead.)

6. CHAMPS Contracts Management Subsystem

Effective September 18, 2009, the Contracts Management (CM) Subsystem in CHAMPS will be implemented for managed care contracts and certain general service contracts. The CM Subsystem generates the enrollment files (834 files) and remittance advice files (820 files) for the managed care plans. The programs contained in the CM Subsystem include: Medicaid Health Plans, Prepaid Inpatient Health Plans, Habilitation Support Waiver, Healthy Kids Dental, MIChild Health and Dental Plans, County Health Plans, Community Mental Health Service Programs, and Substance Abuse Coordinating Agencies. MDCH will issue a separate upcoming provider bulletin for managed care providers with further details.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Faye Ruhno
Michigan Department of Community Health
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: ruhnof@michigan.gov

If responding by e-mail, please include "CHAMPS Implementation" in the subject line.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Acting Director
Medical Services Administration