



# Michigan Medicaid

## Professional Billing

Michigan Department  
of Community Health



# ICD-10 Implementation

Get Ready!

**HIPAA** ICD-10  
Implementation

# What is ICD-10?

- 10<sup>th</sup> revision of standard medical code sets used for:
  - ✓ Diagnosis codes used by all providers in health care settings (ICD-10-CM)
  - ✓ Procedure codes used for hospital claims and inpatient hospital procedures (ICD-10-PCS)
- Classification of medical code sets
- Does not affect use of CPT or HCPCS
- Required by HIPAA

# Regulatory Requirements

- MDCH recognizes the compliance date of **October 1, 2014**, *thus all MDCH planning efforts will adjust according to this new timeline.*
- All HIPAA covered entities must use ICD-10
- HHS published final regulations (45CFR 162.1002) on January 16, 2009
- Services rendered on and after **October 1, 2014** must use ICD-10-CM and ICD-10-PCS
- ICD-9 codes, based on date of service, will continue to be sent and received for some time

# Why ICD-10?

ICD-9 codes don't provide the needed detail  
ICD-9 has obsolete groupings of disease families  
Provides additional detail for better analysis  
Modernized terminology for:

- New conditions

- New treatments

- New technology

Better information for public health, quality measures  
and bio-surveillance

# Let's Look at an Example

**ICD-9 Code-** E917.0 - Striking against or struck accidentally in sports without subsequent fall

**ICD-10-CM-** Sports injuries now include sport and reason for injury

**So what does this mean?**

## Now 28 possible ICD-10-CM W21 codes for E917.0

W21.00	Struck by hit or thrown ball, unspecified type	W21.4	Striking against diving board
W21.01	Struck by football	W21.11	Struck by baseball bat
W21.02	Struck by soccer ball	W21.12	Struck by tennis racquet
W21.03	Struck by baseball	W21.13	Struck by golf club
W21.04	Struck by golf ball	W21.19	Struck by other bat, racquet or club
W21.05	Struck by basketball	W21.210	Struck by ice hockey stick
W21.06	Struck by volleyball	W21.211	Struck by field hockey stick
W21.07	Struck by softball	W21.220	Struck by ice hockey puck
W21.09	Struck by other hit or thrown ball	W21.221	Struck by field hockey puck
W21.31	Struck by /stepped on by shoe cleats	W21.81	Striking against or struck by football helmet
W21.32	Struck by /skated over by skate blades	W21.89	Striking against or struck by other sports equipment
W21.39	Struck by other sports footwear	W21.9	Striking against or struck by unspecified sports equipment

# Provider Impacts

- More detailed medical documentation will be needed to support the new code set
- Codes will be more specific
- Payments may be impacted by the code selected
- Provider staff must be familiar with the new coding and how it impacts your business
- CPT and HCPCS Codes will not be effected

## Take Home Message!

*You **WILL NOT** be paid if you do not use ICD-10 codes after the Compliance Date of*

***October 1, 2014.***

**Begin preparation now!**

# ICD-10 Resources

- [www.michigan.gov/5010icd10](http://www.michigan.gov/5010icd10)
  - ✓ MDCH specific information including FAQs & other links
  - ✓ GEMS Viewer
  - ✓ Email: [MDCH-ICD-10@michigan.gov](mailto:MDCH-ICD-10@michigan.gov)
  - ✓ Telephone: 1-800-292-2550
- [www.CMS.gov/ICD10](http://www.CMS.gov/ICD10)
- [www.AAPC.com](http://www.AAPC.com)
- [www.AHIMA.org/icd10](http://www.AHIMA.org/icd10)
- [www.BCBSM.com/icd10](http://www.BCBSM.com/icd10)



# **Third Party Liability (TPL)**



# TPL Functions

- CHAMPS has allowed Michigan Medicaid to implement very extensive TPL business functions to ensure that Medicaid pays only for services that are not covered by other insurers.
- Successful TPL functions rely on key strategies which include the following 4 items:

# #1 Cost Avoidance

- Avoiding costs up front before Medicaid pays
- If the Medicaid program determines that a potentially liable third party exists, it must direct the health care provider to bill the third party first before sending the claim to Medicaid. This is known as up front “cost avoidance”

# #1 Cost Avoidance (Billing Tips)

- Always follow the primary insurance guidelines before submitting a claim to Medicaid
- If Medicaid is liable for payment (including Co-Insurance or Deductible amounts)
  - Report the primary payer along with the appropriate Claim Adjustment Reason Code (CARC) provided by the other insurance Explanation of Benefits (EOB), a complete listing of CARC codes can be found on the [Washington Publishing Co website](#).

## #1 Cost Avoidance (Billing Tips Cont)

- Be sure to report ALL other insurances on your claim to Medicaid. Claims will deny if the primary insurer (other than Medicaid) is not reported on the claim with the appropriate CARC code(s) even if they have denied it.
- Do not send EOB's through EZLINK. Use only CARC descriptions.

## #2 Pay and Chase

- Collecting payments that have been made in error
- Whenever the state Medicaid program pays a claim and subsequently discovers the existence of a liable third party, it must attempt to recover the money from the liable third party. This is known as “pay and chase”

## #2 Pay and Chase

- TPL sends out monthly reports directly to Medicaid providers to identify Medicaid paid claims that are believed to be the liability of another payer
  - These reports are available in the Archived Documents link in CHAMPS
- If the provider agrees with the claims identified on the report, the provider is to bill the other insurance entity for these services prior to rebilling Medicaid.

## #2 Pay and Chase Cont.

- The provider has 30 days to review the identified claims and contact TPL for any discrepancies
  - If TPL is **not** contacted within 30 days, the services on the report will automatically be claim adjusted. (Please refer to the report for contact information)
- TPL will complete a claim adjustment after 30 days from the date of the report
  - The claim adjustment will return money to the State of Michigan for the paid claim. After the other insurance makes payment on the claim, the provider may re-bill the claim to Medicaid with the correct other insurance information reported

## #3 Maintaining Accurate TPL Coverage Files

- Capturing/updating insurance coverage information for all Medicaid enrollees
- Both “cost avoidance” and “pay and chase” rely on capturing current information from other insurers and cross-referencing the lists of covered individuals with Medicaid enrollment files

## #3 Maintaining Accurate TPL Coverage Files

- Providers should notify the TPL Database unit if a Medicaid Beneficiary's primary insurance has changed or terminated
  - Complete the DCH-0078 form found on the TPL website at ([www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders) >>Billing and Reimbursement>>Third Party Liability>>Health Insurance
  - Fax the completed form along with any supporting documentation to 517-346-9817
    - Please allow up to 10 business days for your request to be processed

## #4 Federal Deficit Reduction Act of 2005

- The Federal Deficit Reduction Act of 2005 greatly strengthened states' authority to obtain commercial insurance coverage files for cross reference with Medicaid enrollment information
- Consequently, Michigan has made great strides in collecting insurance coverage files from commercial insurers. Through tape matches and auto updates.

## 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

# Common CAS/Reason Codes

- 1 = Deductible Amount
- 2 = Coinsurance Amount
- 3 = Co-pay
- 45 = Contractual amount
- 96 = Non-covered charges

Complete list:

- [www.wpc.edi.com/codes](http://www.wpc.edi.com/codes) >> Claim Adjustment Reason Codes



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Provider

**Claims**

Reference

Member

TPL

Rate Setting

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Contract/MC

Welcome Testuser, Provider. You have logged-in with [redacted] domain and CHAMPS Full Access profile. Links: --Select--



Path: Provider Portal

NPI: [redacted]

Name: [redacted]

Menu

Provider Portal:

Online Services:

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- Initiate New Enrollment
- Manage Provider Information
- Track Application

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- Archived Documents

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- Submit Institutional Claim Inquiry
- Submit Dental
- Submit Professional

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- 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 !



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Welcome Outreach, Training. You have logged-in with [redacted] domain and Provider profile.

Links: --Select--



Path: Provider Portal

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Close

Choose an Option:

[Claim Submission](#)

Claim Submission

[Manage Claims](#)

Manage Claims

[Inquire Claims](#)

Inquire Claims

[RA List](#)

RA List



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Provider Test . You have logged-in with Provider Test 0000000001 domain and Provider profile.

Links: --Select--



Path: Provider Portal

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Close

Choose an Option:

<a href="#">Submit Professional</a>	Submit Professional
<a href="#">Submit Institutional</a>	Submit Institutional
<a href="#">Submit Dental</a>	Submit Dental
<a href="#">Search Template</a>	Search Template



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Provider Test You have logged-in with Provider Test 0000000001 domain and Provider profile.

Links: --Select--



Path: Provider Portal/ Submit Professional Claim

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Close Submit Claim Save as Template Reset

Professional Claim:

Note: Asterisks (\*) denote required fields.

[Billing Instructions](#)

Basic Claim Info

Billing Provider | Pay-To Provider | Beneficiary | Claim | Service

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: 10000000001 \* Type: NPI \* Taxonomy Code:

- Is the Billing Provider also the Pay-To Provider?  Yes  No
- Is the Billing Provider or Pay-To Provider also the Rendering Provider?  Yes  No
- Is this service the result of a referral?  Yes  No

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BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: \*

Last Name: \* First Name: \* MI: Suffix:

Date of Birth: mm dd yyyy \* Gender: \*

Onset of Current Illness/symptom Date: mm dd yyyy Similar Illness/symptom Date: mm dd yyyy

- Does the beneficiary have insurance other than Medicaid?  Yes  No

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CLAIM INFORMATION

+ RELEVANT DATES



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Links: --Select--



Path: Provider Portal/ Submit Professional Claim

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Does the beneficiary have insurance other than Medicaid?  Yes  No

**OTHER INSURANCE INFORMATION**  
Other Subscriber Information

Payer Responsibility Code:  \*

Payer ID Number:  \*

Subscriber Last Name:

Date of Birth:  mm  dd  yyyy

Insured's Group or Policy Number:  \*

Claim Filing Indicator :  \*

Subscriber Member ID:

First Name:  MI:  Suffix:

Gender:

Beneficiary's Relationship:  \*

Total COB Payer Paid Amount: \$  \* [Add Another](#)

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**CLAIM INFORMATION**

RELEVANT DATES

PRIOR AUTHORIZATION/CLIA

CLAIM NOTE

Is this claim accident related?  Yes  No

Does this claim have backup documentation?  Yes  No

**CLAIM DATA**

Patient Account No:



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Provider Test

You have logged-in with Provider Test 0000000001 domain and Provider profile.

Links: --Select--



Path: Provider Portal/ Submit Professional Claim

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Close Submit Claim Save as Template Reset

### CLAIM INFORMATION

+ RELEVANT DATES

+ PRIOR AUTHORIZATION/CLIA

+ CLAIM NOTE

? Is this claim accident related?  Yes  No

? Does this claim have backup documentation?  Yes  No

#### CLAIM DATA

Patient Account No.:

Medicaid Deductible Amount: \$

Diagnosis Codes: 1:  \* 2:  3:  4:

### BASIC LINE ITEM INFORMATION

#### BASIC SERVICE LINE ITEMS

Service Date From:  mm  dd  yyyy \*

To:  mm  dd  yyyy \*

Place of Service:  \*

EMG :  \*

Procedure Code:  \*

Modifiers: 1:  2:  3:  4:

Submitted Charges: \$  \*

Diagnosis Pointers: 1:  \* 2:  3:  4:

Units/Quantity:  \*

EPSTD/Family Planning:



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Provider Test You have logged-in with Provider Test 0000000001 domain and Provider profile.

Links: --Select--



Path: Provider Portal/ Submit Professional Claim

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Close Submit Claim Save as Template Reset

**BASIC LINE ITEM INFORMATION**

**BASIC SERVICE LINE ITEMS**

Service Date From: mm dd yyyy To: mm dd yyyy  
 10 26 2008 \* 10 26 2008 \*

Place of Service: 11 \* EMG : NO \*  
 Procedure Code: 99222 \* Modifiers: 1: 2: 3: 4:

Submitted Charges: \$ 135.00 \* Diagnosis Pointers: 1: 1 \* 2: 3: 4:

Units/Quantity: 1 \*  
 EPSDT/Family Planning:   
 Rendering Provider ID: (If different from header) Type: Taxonomy Code:

National Drug Code: Quantity: Add Another

Add Service Line Item Update Service Line Item

**Previously Entered Line Item Information**

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	
	From	To		1	2	3	4	1	2	3	4			

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Welcome Test You have logged-in with Provider Test.0000000001 domain and Provider profile.

Links: --Select--

Path: Provider Portal/ Submit Professional Claim/ Search Templates/ Submit Professional Claim

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Close Submit Claim Reset

**BASIC SERVICE LINE ITEMS**

Service Date From:  \* To:  \*

Place of Service:  \* EMG :  \*

Procedure Code:  \* Modifiers: 1:  2:  3:  4:

Submitted Charges: \$  \* Diagnosis Pointers: 1:  \* 2:  3:  4:

Units/Quantity:  \*

EPSDT/Family Planning:

Rendering Provider ID:  (If different from header) Type:  Taxonomy Code:

National Drug Code:  Quantity:  Units:  [Add Another](#)

[Add Service Line Item](#) [Update Service Line Item](#)

**Previously Entered Line Item Information**

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: \$135.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	
	From	To		1	2	3	4	1	2	3	4			
1	10/26/2008	10/26/2008	99222					1				135	1	<a href="#">Insurance Info</a> <a href="#">Copy</a> <a href="#">Delete</a>

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Welcome [redacted]. You have logged-in with [redacted] domain and **Provider** profile. Links: --Select--



**Path:** Provider Portal/ Search Templates/ Submit Institutional Claim/ Search Templates/ Submit Institutional Claim/ Submit Claim Insurance Info

Menu

Close Basic Claim Form Reset

**Institutional Claim:**

Note: asterisks (\*) denote required fields. [Billing Instructions](#)

**INSURANCE INFORMATION**

To save the information, Click 'Basic Claim Form' button.

Does the Beneficiary have insurance other than Medicaid?  Yes  No

**OTHER INSURANCE INFORMATION**

**1. Service Line Other Payer Information**

Primary Payer Responsibility: [dropdown] \* Amount Paid: \$ [input] \*

1. Reason Code: [input] Amount: \$ [input] Adjustment Quantity: [input] [Add Another Reason Code](#)

2. Reason Code: [input] Amount: \$ [input] Adjustment Quantity: [input]

[Add Another Payer](#)

# What is Buy In

- Premium Assistance for dual eligible beneficiaries
- All 50 states participate
- Each state has own policy

# Purpose of Medicare Buy In Unit

- Pay Medicare Part A and Part B premiums for dual eligible Medicaid beneficiaries
  - More than 50 percent are under age 65 due to disability
- Pay Medicare Part D claw back for all dual eligible Medicaid beneficiaries and correct Medicare Part D errors
- Add and remove Medicare coverage on Bridges
- Correct Medicare Buy In Status (MBS) Codes on Bridges
- Update Medicare data Champs
- Levels of eligibility, based on FPL are:
  - QMB, SLMB, ALMB, QDWI

# Process of Buy In

- Notified of Buy In eligibility
- File is sent to CMS once a month
- CMS approves or denies Buy In request
- CMS sends approval dates to SSA
- SSA updates all Medicare verification systems
- Process can take up to 120 days

# Other Transactions

- Accretions from CMS
  - Newly enrolled dual eligible's
    - Primarily SSI beneficiaries
    - Beneficiaries turning 65
- Death Notifications
- Moved out of State notifications
- Medicare termination dates
- Update Bridges/Champs to reflect correct information received from CMS

# Buy In Errors

- DHS workers code Medicare Buy In eligibility using beneficiaries income and household assets
- Buy In unit makes corrections and or additions to:
  - Name spelling
  - Date of Birth
  - Gender
  - Social Security Claim Number
  - Social Security Number
  - Other Insurance Codes for Medicare
  - Medicare Buy In Status Codes

# Aliens

- Verify information on clients age 65 or over regarding residency
- Make corrections on Other insurance code in Bridges
- Keep track of that information
- Send memos to DHS specialist for verification
- Receive information regarding citizenship from claims, providers and beneficiaries
- Over 1,000 active beneficiaries with Alien Status

## TPL Website

- For more information regarding the Michigan Medicaid Third Party Liability Unit please visit our new website at

[www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders) >>

Click on “Billing and Reimbursement”  
link>>Click “Third Party Liability”

# SPEND DOWN

- Spend-down coverage and how it works
- Finding the DCH policy
- Caseworker responsibility
- Beneficiary responsibility
- Provider responsibility
- Aka Medicaid Deductible

# Medicaid Deductible

- Provider Manual in the Chapter **Beneficiary Eligibility**
- **Section 4-Medicaid Deductible Beneficiaries** (Spend-down)
- Medicaid deductible means that the beneficiary must incur ***medical expenses*** each month equal to, or in excess of, an amount determined by the local DHS worker to qualify for Medicaid.
- **Process:**
  - Beneficiary presents proof of ANY medical expense incurred to the DHS worker. Items they can use e.g., care from hospitals, doctors, clinics, dentists, drugs, medical supplies and equipment, health insurance premiums, transportation to get medical care, personal assistance services, adult home help services, and other services from Community Mental Health.

# Medicaid Deductible

- Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. In other words provider would not have to verify concrete amounts via EOB-this will speed up the process to get that eligibility started for the beneficiary.
- **Beneficiary should be advised to contact their respective DHS caseworkers within 10 days of receipt of any charges they may use to satisfy their deductible**
- **Spend down is also called Medicaid Deductible**

# Great NEWS!

- Providers now have access to a website that will display the Spend-down amount in their eligibility response on their 'MI Health Plan Benefits' page
  - and 270/271 transaction.
- <https://healthplanbenefits.mihealth.org>

# MI Health Plan Benefits

Login

Welcome to MI Health Plan Benefits Website  
*Please login below:*

<b>Login</b>	Username:
	<input type="text"/>
	Password:
	<input type="password"/>
<input type="submit" value="Submit"/>	



- » [I can't access my account!](#) «
- » [Medicaid Provider Manual](#)
- » [Enrollment Form](#)



Send email to [MedicaidEligibility@mphi.org](mailto:MedicaidEligibility@mphi.org) with questions or comments about this web site.  
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[Contact Us](#) | [Help](#)

# MI Health Plan Benefits

Home > Individual Eligibility

**Eligibility**

Eligibility Service:

**Beneficiary ID**

Medicaid ID:

**Name**

Last:  First:

Middle:

**Social Security Number**

SSN:

**Date of Birth (MM/DD/YYYY)**

DOB:

**Coverage Period \* (MM/DD/YYYY)**

Start Date:  End Date:



Residence County	63 OAKLAND
FIA Office	
Case Number	
Worker Load	

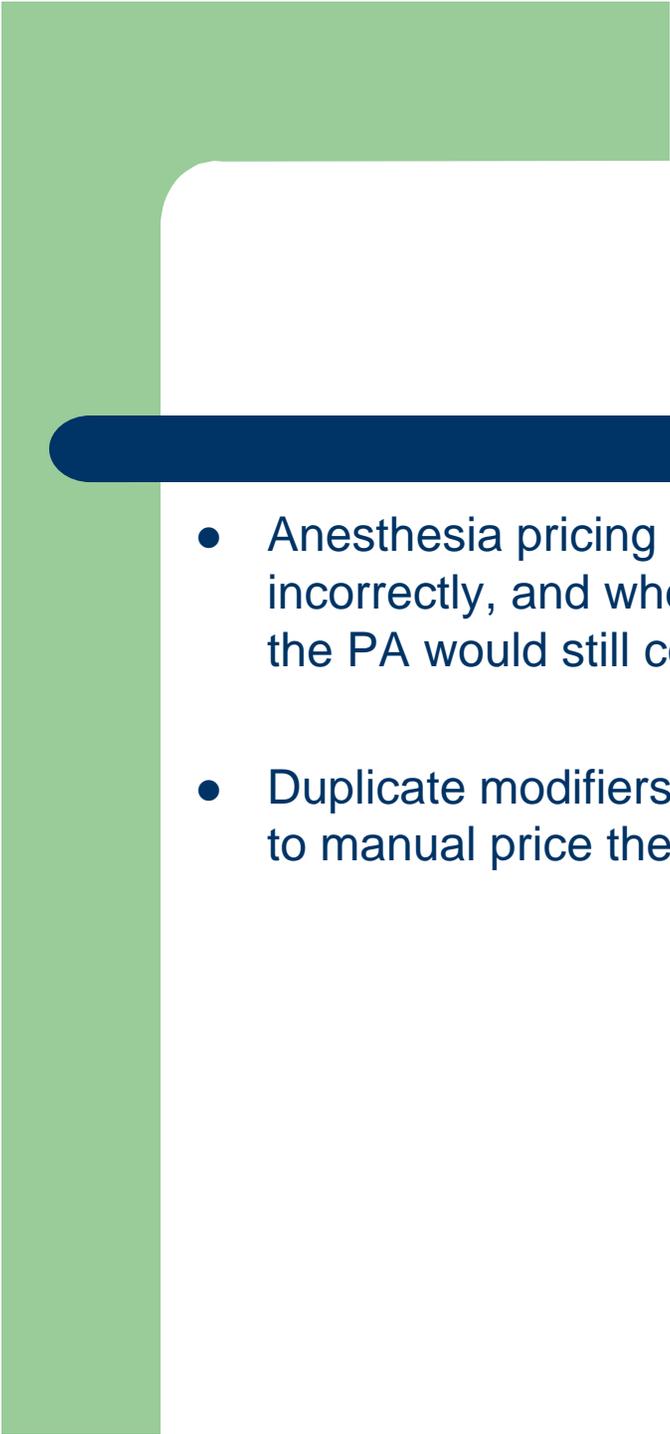
Member/ Patient Name	Gender	Date of Birth	Coverage Period
	Male		09/01/2011 To 09/30/2011

Status	Benefit Plan	Comments	Dates
Co-Pay	SPENDOWN	<b>Patient Pay: \$1400.00</b>	09/01/2011 To 09/30/2011

↑  
Spend-down amount per DHS for current month only.

# CHAMPS Updates

- Other Insurance Adjustment Issue When trying to adjust the CARC's or RARC's on the Other Insurance Screen it would flag a stack trace error.
  - Fixed 06/24/12
- When a claim has more then 1 carrier we should not use our reduce CARC 45 logic to reduce the billed amount. The reduce can not be done on both primary and secondary.
  - Fixed 06/24/12
- Added additional Filter boxes
  - Can search by date in first or second field.
  - Claim limit list now shows Modifiers
- Reinstatement of Chiropractic Services for adults
  - This caused claims billed between June 1, 2012 and June 22, 2012 to reject. MDCH will recycle those claims on an upcoming remittance advice.

- 
- 
- Anesthesia pricing when a blanket PA was on the claim was paying incorrectly, and when the providers removed the PA on the adjustment the PA would still copy to the new claim.
  - Duplicate modifiers on Ambulance claims would not allow processors to manual price the claim line

# Questions ?

- Sign up with a representative for
- One on One Open House Sessions.
  - Email questions at [providersupport@michigan.gov](mailto:providersupport@michigan.gov)
  - Or Call
  - 1-800-292-2550