PROVIDER INQUIRER

October 1st, 2008

www.michigan.gov/mdch

Featured Articles

Application of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)

The policy implementing the LOCD was incorporated into the Medicaid Provider Manual, Nursing Facility Coverages chapter, under Section 4 – Beneficiary Eligibility and Admission Process. This chapter may be found at the link below:
http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Below is a list of possible scenarios that describe when the LOCD is to be applied online, and when it is not. Again, please refer to the Medicaid Provider Manual mentioned above for specific guidelines:

1. New Medicaid admission/enrollee = apply LOCD online within 14 calendar days of admission/enrollment.
2. Current nursing facility resident > applied for Medicaid = apply LOCD online within 14 calendar days of notice of Medicaid application. **Do not** wait for confirmation of Medicaid financial eligibility from DHS.
3. New Medicaid admission > hospital stay within 14 calendar days of admission > LOCD **not** applied prior to hospital stay > discharged to home or different provider = apply LOCD online within 14 calendar days of nursing facility admission date based on medical record prior to hospital stay. (If beneficiary is still at hospital and 14th day has arrived, conduct LOCD based on medical documentation/notes prior to leaving for hospital.)
4. New Medicaid admission > hospital stay within 14 calendar days of admission > LOCD **not** applied prior to hospital stay > re-admission to same provider = apply LOCD online within 14 calendar days of original nursing facility admission date. (If beneficiary is still at hospital and 14th day has arrived, conduct LOCD based on medical documentation and/or notes prior to leaving for hospital.)
5. New Medicaid admission > LOCD applied > hospital stay > **re-admission** to same provider = do not apply second LOCD

6. New Medicaid admission > LOCD applied > hospital stay > discharged to home or to different provider > admitted to original provider at later date = apply LOCD online within fourteen calendar days of admission.
7. New Medicaid admission > LOCD applied > discharged from previous provider > new admission to a new provider = new provider apply LOCD online within 14 calendar days of admission.
8. New Medicaid admission > beneficiary deceased within 14 calendar days of admission > LOCD not applied prior to death = apply LOCD online within 14 calendar days of admission based on medical records.
9. New Medicaid admission > admitted as hospice patient (Level of Care Code 16) = do not apply the LOCD
10. Current hospice beneficiary > disenrolled from hospice > level of care code changed from 16 to skilled 02 = apply LOCD online within 14 calendar days of hospice disenrollment.
11. New Medicaid admission > applied LOCD online within 14 calendar days of admission > beneficiary went hospice (Level of Care Code 16) > beneficiary disenrolled from hospice and went Skilled (Level of Care Code 02) = apply a second LOCD online within 14 calendar days of hospice disenrollment
12. Current beneficiary > disenrolled from HMO = apply LOCD within 14 days of HMO disenrollment.

Do not apply a second LOCD for the following reasons:

1. First or last name spelled incorrectly.
2. Last name entered as first, first name entered as last.
3. Incorrect date of birth.
4. Door through which the beneficiary initially qualified is now another door of eligibility.
5. Received Medicaid Beneficiary ID after LOCD entered online. Enter the Medicaid Beneficiary ID to the initial LOCD you created online. Do not create another LOCD just to add the Medicaid Beneficiary ID.

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THE CHAMPS CORNER

Community Health Automated Medicaid Processing System

Congratulations On A Successful Revalidation

Thanks to all those who utilized CHAMPS for your diligence and patience during the CHAMPS revalidation period! MDCH is proud to say that in just six months over 38,000 applications were accessed and approximately 34,000 NPIs and their enrollment information were revalidated or newly enrolled in CHAMPS. The remaining legacy enrollments that were not revalidated must be closed because their information could not be verified and therefore has not been appropriately maintained. While many of these enrollments are no longer in use we realize that there will be enrollments that have been closed that are still in use and still require maintenance in CHAMPS. Any revalidation application that was accessed and had at least one step completed prior to October 1 will remain accessible to providers for up to 30 days after October 1. Any application that is not accessible after October 1 must be manually reopened by Provider Enrollment staff. Anyone requesting access to an enrollment that was closed due to the revalidation deadline must provide proof of their rights to the enrollment (see DCH-1401 on the CHAMPS information website at www.michigan.gov/mdch, then click on CHAMPS).

For all those active enrollments in CHAMPS we ask that all domain administrators continue to cooperate with their individual providers' other business partners in granting domain access. It is the responsibility of the provider, their staff, and business partners (i.e. medical/dental groups, hospitals, clinics, etc.) to determine who requires access to properly monitor and update the individual's enrollment information including association to billing provider NPIs.

Again, MDCH would like to thank everyone for participating with Medicaid and making the CHAMPS provider enrollment system a success!

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New Policy Bulletins

The bulletins below were published during the previous month. It is very important that all providers are aware of new Policy Bulletins that are published. All applicable Policy Bulletins will be incorporated into the new quarter of the on-line updated Medicaid Manual. To view the new policy bulletins online you can visit www.michigan.gov/medicaidproviders >> Policy and Forms. If you have any questions on the Policy Bulletins above, please contact Provider Inquiry at 1-800-292-2550 or ProviderSupport@michigan.gov.

Issue Date	Bulletin Number	Subject
September 2008	MSA 08-48	Sanctioned Provider Update - September
September 19, 2008	MSA 08-47	Correction to FY 2008 Outpatient Uncompensated Care DSH Pool Distribution (Attachment correction to MSA 08-34)
September 9, 2008	MSA 08-44	New Coverage of Immunization Codes
September 1, 2008	MSA 08-46	Updates to the Medicaid Provider Manual - October 2008
September 1, 2008	MSA 08-45	Increased Fee Screens for Preventive Medicine Visits and Specific Newborn Codes
September 1, 2008	MSA 08-43	Return of Unused Prescription Drugs to Pharmacies by Nursing Facilities
September 1, 2008	MSA 08-42	Mandatory Enrollment of Pregnant Women into Medicaid Health Plans
September 1, 2008	MSA 08-41	Facility Innovative Design Supplemental (FIDS) Program for Inpatient Long Term Care Facilities
September 1, 2008	MSA 08-39	New Service Coverage for the Plan First! Program
September 1, 2008	MSA 08-38	Statewide Implementation of the EZ Link Claim Documentation Process

September 1, 2008	MSA 08-32	Revisions to the Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual
August 26, 2008	MSA 08-40	Sanctioned Provider Update - August
August 26, 2008	MSA 08-36	Technical Corrections, Clarifications and Moratorium Changes to the School Based Services Policy

Proposed Medicaid Changes

Below are the proposed Policy Bulletins that are posted online. Please review them online at www.michigan.gov/medicaidproviders >>Policy and Forms. Make sure all comments have been submitted by the Comment Due Date below.

Comment Due Date	Notice Number	Subject
October 1, 2008	0826-Prac	Increased Fee Screens for Preventive Medicine Visits and Specific Newborn Codes

Provider Inquirer Cancelled for November and December

In order for the Outreach Department to assist in testing of the various subsystems of CHAMPS (due to be released in Spring, 2009), the November and December issues of the Provider Inquirer have been cancelled. The Provider Inquirer will resume January, 2009.

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Frequent CMS 1500 Billing Errors

Medicaid billed as Primary when Other Insurance/Medicare is available. Medicaid must be billed as the payer of last resort. Not billing appropriately will cause lengthy pends and eventual rejections. Claims submitted electronically must have the insurance information entered in the 2300 and 2400 loops. When billing paper, box 11 must include primary coverage and box 9 must include secondary coverage. Medicaid should not be identified as a carrier on the claim.

Billing a new claim when the provider should be billing for a claim replacement. A claim replacement is necessary to correct a claim that is considered paid in the system. Electronically loop 2300 is to be used to report 7 for claim type followed by the 10 digit claim reference number (of the last approved claim). When billing paper, report in box 22. A comment in remarks should be included regarding the change.

When it is necessary to bill for a non emergent inpatient authorization or prior authorized service. It is necessary to include the 9 digit pacer/prior authorization number on the claim. Many providers place numbers/letters on the claim that do not relate to the Medicaid Prior Authorization # causing rejections (the 190R, for example). Enter in loop 2300 electronically and box 22 for the paper claim form.

Providers must complete the service facility information and NPI if the service is provided somewhere other than the billing address. Many providers are not completing the field when providing services in the hospital settings. The information must be reported in loop 2310 electronically. When submitting paper report in box 32a.

Providers must complete a hospital admission date when a physician provides services in the inpatient setting. This is loop 2300 electronically. Enter in box 18 in the FROM date field on paper claims.

DME providers must provide the hospital discharge date on the claim when billing for rental items exempt from obtaining a Prior Authorization for three months after the discharge date. This is loop 2300 electronically. Enter in box 18 in the TO date field on paper claims.