

PROVIDER INQUIRER

August 1st, 2008

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Frequent Hospital Billing Errors:

1. Inpatient Hospital Co-Payment Requirements

Providers are questioning the reason for the \$50.00 co-payment deductions from their inpatient claims when the beneficiary is Medicare eligible. Medicaid deducts the co-payment when Medicare Part A has exhausted on an inpatient admission. Medicaid would be considered the primary payer of the majority of the bill and Medicare is responsible for Part B services.

2. Patient Pay is being deducted in error on an Inpatient Bill when a patient came from a Nursing Home.

In the event a Nursing Home resident is admitted through the emergency room, the claim must reflect an admission source code of 5 instead of 7. The 5 explains that the patient was transferred from a Nursing Home and our system will determine from the date of admission if the Patient Pay is to be deducted. When billing with the admission source of a 7 (patient came through the emergency room) the Patient Pay will automatically be deducted. The Patient Pay will be

deducted from the provider that has the patient in their facility on the first day of the month.

3. Outpatient Claims rejecting 051 (Procedure code not allowed for primary diagnosis)

Even though Medicaid is paying by the OPPS determination, our system is still checking the diagnosis code with the revenue code being billed on your claim. The 051 rejection is caused when billing the revenue code 450 with a diagnosis code that is not considered an emergency. A list of diagnosis codes that will set the 051 edit is provided on our website under; Provider Updates/Provider Tips/Hospital/Uncovered Emergency Diagnosis Codes.

4. Outpatient Claims being billed as multi-page claims in error.

Medicaid has been receiving multi-page outpatient claims for entry. Medicaid does not accept outpatient multi-page claims. Each page of services must be totaled separately.

Medicaid does allow **series billed** (more than one date of service on one claim) on Outpatient Claims. Series billed claims can only be services rendered in one calendar month per claim.

The only services that can be series billed are:

- Therapies- physical, occupational or speech.
- Dialysis and Radiation Therapy.

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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
July 2008	MSA 08-31	July Sanctioned Provider List Update

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
August 18, 2008	0820-MHP	Mandatory Enrollment of Pregnant Women into Medicaid Health Plans
August 18, 2008	0818-Dental	Implementation of Age One Dental Visit and Fluoride Varnish Program for Infants and Children up to Age Three
August 6, 2008	0817-Hospital	Inpatient Hospital Payment Reductions

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Provider Enrollment Announcement:

The Revalidation deadline of August 31, 2008 has been extended through September 30, 2008. Providers that have not revalidated by the deadline will be disenrolled from Medicaid and will not be eligible to receive reimbursement for claims submitted on or after October 1, 2008.

Revalidation of Groups:

60 days remain until the revalidation deadline of September 30, 2008. Approximately 24,000 providers have submitted their applications and have been approved. Although many Medicaid providers (Groups, Individuals, Facilities, Agencies and Organizations) have completed this process, MDCH has discovered that the majority of those that have not revalidated are group practices.

A group practice is the business for which individual providers render services, for instance a group of doctors, dentists, nurse practitioners, etc....

In March, 2008, letters on green paper were sent out to all provider types informing them of the new on-line CHAMPS Provider Enrollment system. A letter including an application ID was sent to each individual, group, facility, agency and organization. The application ID represents that particular entity's enrollment application. MDCH recommends that those providers that did not receive the green letter contact the CHAMPS helpline at: 1-888-643-2408.

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MDCH recognizes that many Provider groups may not have revalidated their groups in CHAMPS because MDCH has never issued Medicaid legacy id's to groups. This may also be the reason why many group practices did not report their group NPI number to Medicaid prior to the implementation of NPI on October 1, 2007. In order to receive payment from Medicaid, group practices must be enrolled in Medicaid. If the group practice did not report the practice NPI to MDCH prior to the October 1, 2007 NPI implementation, an application ID was not generated by the CHAMPS Provider Enrollment system. Such groups will need to complete a New Enrollment in CHAMPS and may request retro-enrollment on the application.

The group practice will need to go into CHAMPS and revalidate the practice information first, wait for the application to be approved and then revalidate each individual provider.

MDCH offers various training tools on the CHAMPS webpage to assist Providers in the revalidation process. To view this information visit: [>>CHAMPS](http://www.michigan.gov/mdch).

MDCH also offers a CHAMPS helpline that can address questions providers may have regarding the Provider Enrollment system. The CHAMPS hotline can be reached at: 1-888-643-2408 or by email CHAMPS@michigan.gov.