

PROVIDER INQUIRER

June, 2010 Quarterly Edition

www.michigan.gov/mdch

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Medicare/Medicaid Inpatient Hospital Billing

Some providers are incorrectly completing inpatient claims to Medicaid after Medicare. When billing Medicaid after Medicare Part A has exhausted prior to or during the hospital stay, the provider must:

- 1.) Use the correct Occurrence Code A3. This identifies Medicare Part A is exhausted. The date Medicare A exhausted must be reported with the Occurrence Code A3.
- 2.) Reflect the number of non-covered days by Medicare. These are the days after the date that Medicare A benefits became exhausted. The number of covered days and non-covered days are considered **Medicare** covered and non-covered days, so the proper number of days from the total number of days billed on the claim must be shown.
- 3.) Medicare must be billed for the Medicare Part B services from that inpatient stay when Medicare Part A is exhausted. Medicaid must be billed for the Medicaid covered days of the hospital stay after Medicare Part B has paid and the claim must reflect the Medicare B payment.
- 4.) Proper CAS codes must be used to identify the information from the Medicare EOB. The co-insurance from Medicare Part B benefits, and the non-covered charges from the Medicare A benefits.

Many providers are only reflecting the co-insurance from the Medicare Part B coverage which will cause an incorrect Medicaid payment.

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When billing inpatient claims to Medicaid after Medicare, when Medicare becomes effective during the hospital stay, providers must:

- 1.) Indicate the payment received from Medicare on the claim to Medicaid.
- 2.) Use the correct Occurrence Code A2. This identifies Medicare A benefits did not start until after the patient was admitted to the hospital. The effective date of Medicare coverage follows the A2.
- 3.) Reflect the number of non-covered and covered days by Medicare. The days prior to the effective date of the Medicare coverage are considered non-covered days and the days covered would be the effective date of the Medicare coverage and after. The number of covered and non-covered days are considered **Medicare** covered and non-covered days, so the proper number of days from the total number of days being billed on the claim must be shown.
- 4.) Proper CAS codes must be used to identify the information from the Medicare EOB. The deductible, co-insurance, and non-covered charges prior to the Medicare effective date could be included.

Many providers do not reflect the proper information causing incorrect payments from Medicaid.



State of Michigan Offices will be closed

Monday, July 5, 2010

In observance of the 4th of July Holiday



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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
May 1, 2010	MSA 10-17	Revise Eligibility Criteria for the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW); Add New Waiver Services for the SEDW and the Children's Home and Community-Based Services Waiver Program for Children with Developmental Disabilities (CWP)
May 1, 2010	MSA 10-16	Prior Authorization and Coverage of Mobility and Custom Fabricated Seating for Beneficiaries in the Community and in Nursing Facilities; Mobility and Seating Evaluation and Justification Form (MSA-1656) for All Beneficiaries; and Revised Special Services Prior Approval-Request/Authorization Form (MSA-1653-B)
May 1, 2010	MSA 10-15	Reporting National Drug Codes (NDC) for Physician Administered Drugs and Tamper Resistant Prescription Pads
May 1, 2010	MSA 10-14	Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) Code Updates for Laboratory Services and Immunizations
May 1, 2010	MSA 10-13	Implementation of National Council for Prescription Drug Programs (NCPDP) 20.9 for Coordination of Benefits (COB) Claims
April 1, 2010	MSA 10-12	Beneficiary Change in Enrollment Status During an Episode of Care
April 1, 2010	MSA 10-11	Change to Pre-Admission Certification and Evaluation Review (PACER) Requirement
April 1, 2010	MSA 10-10	Hospice Services for Beneficiary Receiving Private Duty Nursing

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April 1, 2010	MSA 10-09	School Based Services Summer Quarter Random Moment Time Study Parameter Change and Cost Reconciliation Information Clarification
April 1, 2010	MSA 10-05	Complex Care Prior Authorization and Annual Pulmonary Evaluation Processes
March 1, 2010	MSA 10-08	Medicaid Health Plan Pharmacy Carve-out
March 1, 2010	MSA 10-07	Citizenship Verification for MICHild Eligibility
March 1, 2010	MSA 10-06	Updates to the Medicaid Provider Manual; Healthcare Common Procedure Coding System (HCPCS) Code Changes

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
June 25, 2010	1019-Hearing	Changes in Hearing Aid Standards of Coverage and Documentation Requirements for Unilateral Hearing Loss
June 24, 2010	1020-Pharm	Pharmacy Vaccine Administration Reimbursement for Seasonal Influenza I
June 23, 2010	1017-Eligibility	Medicaid Eligibility Reviews at Closure

Topic Suggestions for the Provider Inquirer:

Do you have a particular billing topic you would like Outreach and Education to address in the next quarterly edition of the Provider Inquirer? If so, submit your suggestion to: provideroutreach@michigan.gov. In the subject line type: Provider Inquirer. Please submit your suggestion(s) at least one month prior to the next edition, Outreach and Education will try to accommodate your suggestion. The Provider Inquirer is released the third month of the quarter (i.e. March, June, September and December).

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THE CORNER

Community Health Automated Medicaid Processing System

CHAMPS Updates

Since September 2009, CHAMPS has adjudicated more than 15 million state medical assistance claims. Many improvements have been made to CHAMPS including reduction in payment and adjudication errors, responsiveness to claim inquiries, and remittance advice reporting. Many of these improvements are the direct effect of provider communication with the Provider Support Hotline and the CHAMPS Helpline. The Provider Support Hotline has logged, researched, and tracked more than five hundred issues reported by thousands of provider staff. The number of inquiries on related issues has been too numerous to respond to individually so the Provider Relations Unit has developed the CHAMPS Provider Update Table on the CHAMPS informational website to keep provider staff informed of known CHAMPS issues. While the CHAMPS Provider Update Table does not contain all known issues, it is meant to represent issues that generate the most inquiries. All issues are given equal attention but many are difficult to relate in a common format to all audiences. Communication with individual providers and provider associations is used when possible.

CHAMPS users may have noticed that the CHAMPS Helpline phone number has been replaced by the Provider Support Hotline phone number on the CHAMPS informational website. The CHAMPS Helpline is still accessible through the new options available when calling the Provider Support Hotline at 1-800-292-2550, option 3. Errors in claims adjudication should still be reported directly to the Provider Support Hotline at 1-800-292-2550, option 5. Thank you for your patience and assistance as we work together to improve CHAMPS and State of Michigan medical assistance.