PROVIDER INQUIRER

March 1st, 2008

www.michigan.gov/mdch

Featured Articles

Clarification on Scope/Coverage Codes

The Provider Consultant Unit has seen an increase of inquiries regarding rejection 023 when the beneficiary is showing a scope/coverage of 2C, 2H, or 2B.

When a provider comes across these types of coverage codes they should be aware that no Medicaid coverage exists.

For scope/coverage 2C and 2H the beneficiary is not covered until they incur sufficient medical expenses to meet the deductible amount. Once the deductible amount is met, the scope/coverage is changed to 2F.

For scope coverage 2B the beneficiary has coverage for Medicare Part B coinsurance and deductibles only.

Please refer to the Beneficiary Chapter, Section 2 of the Provider Manual to obtain the scope coverage code list.

The provider should make sure the eligibility verification system is checked on each beneficiary to ensure that payment is available for the service performed. For information on how to navigate the EVS system please refer to the MDCH website at www.michigan.gov/medicaidproviders and click on The MI Eligibility Verification System (EVS).

For questions regarding scope/coverage codes you may contact the provider Inquiry Line at 1-800-292-2550 or e-mail Provider Support at ProviderSupport@michigan.gov.

Proposed Medicaid Changes

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

Comment Due Date	Notice Number	Subject
March 19, 2008	0802-CSHCS	CSHCS Non-Emergency Medical Transportation Policy

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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 >> Medicaid Policy Bulletins. 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
March 1, 2008	MSA 08-16	Update to the Medicaid Access to Care Initiative (MACI) Payment Schedule
March 1, 2008	MSA 08-15	Updates to the Medicaid Provider Manual
March 1, 2008	MSA 08-14	Sanctioned Provider List
March 1, 2008	MSA 08-13	Provider Enrollment Changes
March 1, 2008	MSA 08-12	MDCH CHAMPS Web Page Re-Design
March 1, 2008	MSA 08-11	New Place of Service Code for Temporary Lodging; Clarification of Claim Completion for Service Facility Location; Claim Reporting Requirements for the Provider Tax Identification Number
March 1, 2008	MSA 08-10	Clarification of Medicaid Wheelchair Coverage Policy for Nursing Facility Residents
February 22, 2008	MSA 08-09	Adult Benefits Waiver Enrollment
February, 2008	MSA 08-06	Sanctioned Providers Update
February 1, 2008	MSA 08-05	Changes to Pharmacy Claim Submission Requirements
February 1, 2008	MSA 08-04	Elimination of Dispensing Fees for Medical Supplies Covered Under the Pharmacy Benefit
February 1, 2008	MSA 08-03	Tamper Resistant Prescription Pad Policy

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THE CHAMPS CORNER

Community Health Automated Medicaid Processing System

Alert! The Michigan Medicaid WebPages are changing on March 10 - your internet browser Bookmarks/Favorites will need to be updated!

Provider Revalidation "Go Live"

Many Providers have been holding their new enrollments while the legacy Provider Enrollment System has been frozen for data conversion and clean-up. When CHAMPS is activated on the Single-Sign-On, and therefore available for provider access for revalidation and new enrollments, Providers will need to consider what tasks to tackle first. Because of inherent dependency of Individual Providers who must associate themselves to revalidated and approved Billing Entities (Groups, Facilities, Agencies, and other Organizations) it is recommended that enrollments/revalidations are completed in CHAMPS in this order (some may not apply):

1st) Revalidate Group
2nd) Enroll New Group
3rd) Revalidate FAO
4th) Enroll New FAO
5th) Enroll New Individuals
6th) Revalidate Individuals

There are three Fee-For-Service Enrollment Types that you will likely find in the CHAMPS Provider Enrollment Subsystem (depending on your user profile, you may see more or less) –
1) Facility/Agency/Organization,
2) Groups, and
3) Individual/Sole-Proprietor. For the Enrollment Type Individual/Sole-Proprietor there are two Applicant Types

A.) Rendering/Servicing-Only and
B.) Individual/Sole-Proprietor.

We would like to point out some key considerations and tips to using the system.

All addresses (Servicing Location, Correspondence Address, Owner Address, etc.) need to be validated to ensure they are uniform with US Post Office (USPS) standards. A link to the USPS address verification tool (http://zip4.usps.com/zip4/welcome.jsp) is provided in a dropdown menu in the upper right corner of the CHAMPS Provider pages. Any non-standard information that your office needs for internal mail routing of correspondence or remittance advice should be included in the Location's "Doing Business As" name. A "Pay-To" address (where the check is mailed or EFT is registered) does not need to be validated if it already exists at MDCH. A Pay-To address for new enrollments with tax IDs new to MDCH will need to be entered and validated by the provider upon enrollment. The tax ID must be registered with the Michigan Department of Management and Budget's (DMB) Vendor Registration before an enrollment can be initiated in CHAMPS. Once the tax ID is registered with DMB's Vendor Registration and their W-9 is on file there, a provider can begin an enrollment and add the new Pay-To address to CHAMPS.

Enrollments that require an authorized association to a Billing Providers (required for Rendering/Servicing, optional for Sole-Proprietors) cannot be completed and submitted until at least one billing provider has revalidated their enrollment, submitted it to MDCH, and MDCH has approved it. The status ("Approved", "Not Approved"*, or "Denied") of converted Billing Provider associated to an Individual is shown in the Individual Enrollment's list of Associated Billing Providers. The Individual should contact the Billing Provider and/or use their application ID to check the status of their converted Billing Provider. Billing Agents (AKA Vendor, Service Bureau, Clearinghouse, etc.) must also be revalidated/enrolled and approved before any billing provider (Group, FAO, or Sole-Proprietor) can associate/authorize them.

*A status of "Not Approved" is a summary of two other more specific status types:

A) "In Process", meaning the application has not been submitted to MDCH for review/approval yet, and

B) "In Review", meaning the application has been submitted to MDCH for review/approval but has not yet been "Approved" or "Denied".

National Provider Identifier Update:

Effective March 6, 2008, MDCH will close the on-line National Provider Identifier collection tool through the Single Sign-On (SSO). Providers will now report any new NPI (s) through the CHAMPS Provider Enrollment system, scheduled for release March 31, 2008.

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Update on Michigan Medicaid Hospital Audits

MPRO as a contracted agent of the Michigan Department of Community Health has observed the following similarities in incorrect billing among hospital providers based on medical record reviews conducted during the audit process and the Statewide Utilization Review.

MPRO has attempted to use the appeal setting for audits and has sent educational letters to the provider as a result of the Statewide Utilization Review; however these issues need to be communicated to all Michigan Medicaid Hospital Providers for educational purposes.

For Inpatient Hospital Audits Provider Type 30:

1) Missing documentation continues to be an issue whether medical records are scanned at the facility or the provider submits the medical record to MPRO; thus impeding a thorough review and may result in funds being recovered.

2) Prior authorization numbers (PACER authorization) are not being obtained for re-admissions within 15 days or transfers, resulting in a denial and funds recovered.

3) Providers in many instances should query physicians to establish the appropriate diagnosis/procedure, but frequently fail to do so. Hospital coders are responsible for coding the correct diagnoses and procedures.

For Statewide Utilization Review Provider Type 30

1) The Official Coding Guidelines are not being followed correctly. For instance coding the principal diagnosis for obstetric patients when a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of delivery. When an obstetric patient presents with a specific obstetric reason for the admission, (i.e., post dates, preterm labor, hypertension), then that condition is the principal diagnosis. When there are no obstetric reasons for an admission and a complication occurs with delivery, then it is appropriate to code the complication as the principal diagnosis. With cesarean deliveries, the principal diagnosis is the reason for the cesarean section, **unless**, the reason for the admission/encounter is for a different obstetric condition. This is consistent with Coding Clinic.

2) Providers are reporting conditions that do not meet newborn reporting guidelines for "additional diagnosis"; especially conditions not documented as needing future health care needs.

3) Providers continue to include secondary diagnosis codes that are not being monitored, evaluated, treated or will extend the length of stay or require nursing care. Providers must not include secondary diagnoses if the diagnoses do not meet the General Reporting Guidelines for Additional Diagnosis.