

CHAMPS Provider Update Table

Last Updated [2]	Originally Posted Date [3]	Invoice Type [1]	Affected Provider Type [1]	Title	Description	Expectation	Status
					Updates		
2/4/2011	2/4/2011	All	All Providers	Clicking the GO Button	Providers have to click the GO button multiple times to get results	This is an ongoing issue and will be an enhancement completed at a later date	On-going
2/4/2011	2/4/2011	Den	Dental	Limit Rejections on certain codes	Providers are getting B5 and B13 limit edits on D0230 D0240 in error. Dental providers have always had to line bill services (instead of quantity billing on one line) ADA from does not allow a qty billed on the line.	Providers can now bill these codes on separate lines. If doing an adjustment in CHAMPS quantity fields are available. If billing a new claim or submitting adjustment electronically, providers can submit codes on separate lines for reimbursement	Fixed January 21, 2011
2/4/2011	9/21/2010	Inst	Home Health	Multiple visits on the same day	When providers are billing two home health visits on the same day claims were denying in error.	Providers can now bill multiple visits on the same day. Providers encouraged to rebill or adjust affected claims	Fixed January 21, 2011
2/4/2011	2/4/2011	All	All Providers	Prior Authorization	Payable amount on the Prior Authorization is listed as 0.01. Champs is paying 0.01 even though the dollar amounts were manually changed by processors. Claims now are allowed to be overridden by processors.	Providers are encouraged to resubmit or adjust affected claims	Fixed January 21, 2011
2/4/2011	2/4/2011	All	All Providers	Duplicate Edits CARC 18	Issue was originally fixed 6/11/2010. Reason Code 18 (Duplicate of previously paid service) setting on different invoice types. CHAMPS identifies Professional claim and Institutional claims as conflicting against each other in error. Please review the claim limit list at the line level in the Inquire Claim screen detail to confirm whether a claim has been affected by this error.	Providers are encouraged to resubmit or adjust affected claims	Originally Fixed June 11, 2010. Recorrected January 21, 2011
2/4/2011	2/4/2011	All	All Providers	Prior Authorization	Providers getting rejections when billing with an approved PA for additional units. Claims were only allowing Medicaid's Max Daily Allowable amount and not acknowledging a PA for additional units.	Claims now allowing additional units when approved PA submitted with claim. Providers are encouraged to resubmit or adjust affected claims	Fixed January 21, 2011
2/4/2011	2/4/2011	Inst	Nursing Facility/Hospice	Primary Payer requirements	Nursing Facility and Hospice claims must now report all primary insurance payer information, this includes Medicare. Reporting Medicare has not been a prior requirement. It now is a requirement for all NF and Hospice providers. Providers must include all primary payers and appropriate reason codes on claims submitted to MDCH.	Claims will suspend and deny if provider does not report all primary insurance information on claims.	Implemented 1/21/2011
2/4/2011	2/4/2011	All	All Providers	Medicare covered Medicaid noncovered services	Providers were receiving denials for Medicare crossover claims in error when the procedure is covered by Medicare but not covered by Medicaid. If a service is covered by Medicare and Medicare has applied to Co-Insurance or Deductible, Medicaid should be paying up to our allowable amount for those services. When providers are submitting directly to MDCH for services covered by Medicare but not Medicaid they must report the appropriate CARC's.(example CARC 1,2 or 3)	Logic is corrected in CHAMPS. Claims should now reimburse correctly on Medicare primary claims for non-covered Medicaid services.	Fixed January 21, 2011
2/4/2011	2/4/2011	All	All Providers	Limit with RR modifier	MDCH had an issue when providers reported RR modifier on claims. RR was not being recognized on the claim and was causing rejections due to limits.	RR modifier is now being recognized. Providers are encouraged to resubmit or adjust affected claims	Fixed January 21, 2011

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2/4/2011	2/4/2011	Prof	All Providers	CHSCS- Only Beneficiaries	The CHAMPS claims processing subsystem will allow CSHCS to implement detailed provider editing for all providers who bill on the CMS 1500 professional claim format. Professional claims submitted to the CHAMPS claims processing subsystem for CSHCS-only clients on or after April 1, 2011 will reject with B7 & N54 error codes if the appropriate provider is not authorized. The definitions of the error codes are as follows:• Adjustment Reason Code B7 - Provider not certified/eligible • Remittance Remark Code N54 - Claim inconsistent with authorized services	Providers must verify eligibility for the CSHCS-only beneficiaries prior to submitting a claim.	Implementation 04/01/2011
2/4/2011	2/4/2011	All	All Providers	Modifier field in Champs	Providers are getting denials in error when a new line is added or existing line is modified during an adjustment in CHAMPS. Submitted procedure code and submitted modifier should be copied and moved up to the service line. This is causing the claims to deny in error. Both SUBMITTED line and service line should have the same information in them.	If providers are getting denials for modifiers or getting paid incorrect rate when a modifier is billed, please check the claim line to verify that the submitted modifier has moved up to the procedure code line. If not providers are encouraged to submit another claim replacement if the claim is paid incorrectly using the last paid TCN. If claim is denied to submit a new claim	Fixed January 21, 2011
2/4/2011	2/4/2011	Prof	Professional	ABW-ESO Copay	Claims billed for ABW-ESO beneficiaries were not deducting the appropriate \$3.00 copay for professional services on E&M visits.	Providers will notice the \$3.00 copay taken out of claims for ABW-ESO beneficiaries on E/M visits. MDCH to adjust claims previously paid incorrectly.	Projected to be corrected on 03/04/2011. Adjustments scheduled to be done after that date
11/29/2010	11/29/2010	All	All Providers	Invoice Date of Adjustments on RA	The invoice date of the original TCN is reported twice on MSA Remittance Advice for adjustment/void claims. The invoice date should only be reported once and it should belong to the adjustment/void claim, not the original TCN.	The invoice date of the original TCN will not appear on MSA Remittance Advice for the adjustment/void claim. The Inquire Claim filters can be used to find the original TCN's remittance advice where its invoice date was originally reported.	Fixed November 24, 2010
11/29/2010	11/29/2010	All	All Providers	Void Claims on RA	Void claims appearing on MSA Remittance Advice with a status of Paid with a negative dollar amount.	Void claims will now appear with a status of Credited.	Fixed November 24, 2010
11/29/2010	11/29/2010	All	All Providers	CARC 16 and RARC M47 on adjustment but TCN is valid	Extra spaces following Original TCN on electronic adjustment/void claims causes denial with CARC 16, RARC M47	Extra spaces allowed in the Original TCN loop 2300 segment REF02 up to HIPAA allowable length	Fixed November 24, 2010
11/29/2010	11/29/2010	All	All Providers	Timely filing of adjustments	CARC 29, RARC N59 - Timely filing error code setting in error on some adjustment claims.	If claims have denied in error providers are encouraged to resubmit.	Fixed November 24, 2010
11/29/2010	11/29/2010	All	All Providers	Age calculation	CHAMPS has been calculating beneficiary age for date of service incorrectly on some claims causing errors and inappropriate payments.	MDCH continues to mass adjust affected claims to correct the age.	Fixed November 24, 2010
11/29/2010	11/29/2010	All	All Providers	Benefit limits by age	Benefit limits involving ages (CARC B5, RARC N30; CARC B5, RARC N10) - Some services are allowed more frequently or less frequently for certain age groups but CHAMPS was using the most restrictive benefit limit for all ages in some cases.	CHAMPS will now limit benefits by age more accurately. Providers are encouraged to resubmit or adjust affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	All	All Providers	VO and DO policy conflicts	If beneficiary has only a Vision-Only (VO) or Dental-Only (DO) policy on file and a medical claim did not reflect that insurance, the claim was being denied with CARC 22 and RARC MA04.	Medical claims do not need VO and DO policies reported. Providers are encouraged to resubmit affected claims.	Fixed November 24, 2010
2/4/2011	6/11/2010	All	All Providers	CHAMPS Claim Paid but no Paid Date	After a claim reaches a status of "Paid", it should appear on a remittance advice (RA) and 835 and be included in a check or EFT no less than 1 week and no more than 2 weeks later. There can be many causes of claims that have been stuck in a status of Paid but have not been included in a check/EFT or a RA/835. Each week new causes are isolated and resolved.	Fewer and fewer claims are affected each week and claims stuck for newer unknown reasons are analyzed and released each month.	On-going

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2/4/2011	12/7/2009	All	All Providers	Paper Claims Update	Paper claims are being loaded and continue to suspend or deny for missing or invalid data, many are pending in TPL.	MDCH encourages providers to use the Direct Data Entry screens in CHAMPS to submit claims that would otherwise be submitted on paper.	On-going
11/29/2010	7/29/2010	Inst	Hospice	Physician Visits-Co Pay taken out	Currently, the Medicaid co-pay is being taken out of Hospice claims for physician visits. Medicaid co-pays should not be deducted from Hospice Physician visit HCPCS codes.	MDCH will reprocess the affected claims as soon as possible.	Fixed in November 24, 2010
11/29/2010	11/29/2010	Inst/Prof	Multiple	National Drug Code (NDC) associated to HCPCS	CARC 181, RARC M119 - HCPCS/NDC-combination edit denying rebate-exempt HCPCS like immunizations.	Providers must continue to report NDCs. CHAMPS will not deny HCPCS/NDC combinations that are rebate-exempt. Providers are encouraged to resubmit or adjust affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	Inst/Prof	Multiple	National Drug Code (NDC) Rebates	Immunizations should not be denied with CARC 211, RARC M119 because they are rebate-exempt.	Providers must continue to report NDCs. CHAMPS will not deny HCPCS/NDC combinations that are rebate-exempt. Providers are encouraged to resubmit or adjust affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	Inst/Prof	Multiple	LT/RT Modifiers	LT/RT modifier not being read on claim causing benefit limit editing and/or payment reduction.	Providers are encouraged to resubmit or adjust affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	Inst/Prof	Multiple	CCI conflict and modifiers	CCI editing - claims require review with CARC B5 and RARC N10 delaying payment.	Fewer claims will be delayed by CCI editing.	Fixed November 24, 2010
11/29/2010	11/29/2010	Inst/Prof	Multiple	Modifier 25 on E/M codes	New Edit (CARC 4, RARC N20)- Procedure cannot be billed with Modifier 25 - Only certain E/M codes can be billed with modifier 25 - based on CPT guidelines and industry standards.	Only certain E/M codes can be billed with modifier 25. Claims previously paid with modifier 25 on an inappropriate HCPCS/CPT may be denied/adjusted/voided by MDCH.	Fixed November 24, 2010
11/29/2010	11/29/2010	Inst/Prof	Multiple	Duplicate editing recognizing certain modifiers	Duplicate Editing (CARC 18, RARC N30; CARC 18, RARC M86) denying inappropriately despite appropriate modifiers - AS, JW, GP, GO, GN	CHAMPS will consider appropriate modifiers when identifying duplicate claims/services. Providers are encouraged to resubmit or adjust affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	Inst	Ambulance	Institutional ambulance claims and APC editing/pricing	Claims with Type of Bill 013x and ambulance revenue code 054x were only sending outpatient portion through APC pricing.	Providers are encouraged to adjust affected claims.	Fixed November 24, 2010
2/4/2011	9/21/2010	Inst	Home Health	Home Health	An error has occurred with visit codes causing incorrect payments.	MDCH will adjust these claims after the cause of the error has been resolved.	Fixed January 21, 2011
11/29/2010	11/29/2010	Inst	Inpatient	PACER numbers not stored	Institutional Claims - Not recognizing PACER number when billed appropriately with G4 qualifier in HIPAA 837 format	CHAMPS will now recognize the PACER number when reported with either qualifier G1 or G4 in the HIPAA 837 format. Providers are encouraged to resubmit the affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	Inst	Inpatient	Blanket Prior Authorization	Inpatient hospital claims not applying blanket PA correctly causing denials.	Providers are encouraged to resubmit affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	Inst	Inpatient	DRG Mapper	DRG Mapper Software - Oct 2010 Updates - Inpatient claims for dates of service after 10/1/2010 may have denied inappropriately for invalid diagnosis code.	Providers are encouraged to resubmit affected claims.	Fixed November 24, 2010

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11/29/2010	11/29/2010	Inst	Multiple	Physician Co-pay	Institutional claims physician visits - co-pay taken out.	Physician visit co-pay will not be taken out of institutional claims when E/M CPTs are billed on any rev code other than clinic or non-emergency. Providers are encouraged to resubmit affected claims.	Fixed November 24, 2010
12/7/2010	12/7/2010	Inst	Outpatient	October APC Software Update	Quarterly APC software update for October was not complete. Claims with newly added diagnosis codes may have been denied with reason codes 146 or A8 and remark codes MA130 or MA63.	Providers are encouraged to resubmit affected claims. MDCH will soon attempt to reprocess as many affected claims as possible.	Fixed November 24, 2010
11/29/2010	11/29/2010	Prof	Multiple	Bi-lateral editing/pricing	Bilateral Pricing Updates - Additional Fixes - Modifiers 50, LT, and RT (CARC 59, RARC MA125; CARC 4, RARC M69)	Providers are encouraged to adjust affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	Prof	Multiple	Other insurance payment applied incorrectly	Other insurance payment being applied to incorrect line causing underpayment on some services.	CHAMPS will now apply the other insurance payments to the appropriate lines. Providers are encouraged to adjust affected claims.	Fixed November 24, 2010
11/29/2010	11/29/2010	Prof	Multiple	POS not reported on RA	Place of Service not reported on RA because 835 only allows place of service at header. Paper and DDE Claim Submission only allows place of service at line. Affects sorting of claims on MSA Remittance Advice and 835.	The place of service code from the first line of claim will be reported at header on MSA Remittance Advice and 835 so that claims are sorted appropriately.	Fixed November 24, 2010
11/29/2010	11/29/2010	Prof	Physicians	Multiple-surgery pricing reducing non-surgical codes	Multiple Surgery pricing used on non-surgical codes causing reduced allowed amount.	CHAMPS will only apply multiple surgery pricing to surgical procedure codes. Providers are encouraged to adjust affected claims.	Fixed November 24, 2010
2/4/2011	9/21/2010	Inst	Hospice and Nursing Facility		CHAMPS is not deducting voluntary payments when reported on a claim with Value Code 22.	MDCH will attempt to adjust any claims affected by this error after it has been fixed.	Fixed January 21, 2011
<p>Previously resolved issues can be viewed in the CHAMPS Provider Update Table Archive.</p>							