“Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time.”

-Provider Relations
Agenda

- Requirement for Verifying Beneficiary Eligibility
- How to Verify Beneficiary Eligibility
- Verifying Third Party Liability (TPL) Information
- Specific Benefit Plan Assignments
  - Children’s Special Health Care Services (CSHCS)
  - Dental
  - Emergency Services Only (ESO)
  - Prepaid Inpatient Health Plan (PIHP)
  - Spend-down
- Medicaid Provider Trainings
Requirement for Verifying Beneficiary Eligibility

- Per the [Medicaid Provider Manual](#), Chapter Beneficiary Eligibility, coverage determination is the responsibility in most cases by the local county office of Michigan Department of Health and Human Services (MDHHS). Once eligibility is established CHAMPS will issue a mihealth card for new beneficiaries.

- Because of the nature of Medicaid eligibility, coverages/benefit plan assignments may change from month to month and it is necessary for providers to always verify coverage prior to rendering any services.
Requirement for Verifying Beneficiary Eligibility

- Eligibility check within a year: Provider Support will allow for a one time courtesy verification.
  - Providers need to verify eligibility within CHAMPS, MPHI, or other vendor services prior to rendering services.
  - It’s the providers responsibility to grant access to their billing agent/companies in order to verify eligibility.
- Eligibility beyond a year: Please contact Provider Support.
- CHAMPS profiles that can verify beneficiary eligibility:
  - CHAMPS Full Access
  - CHAMPS Limited Access
  - Eligibility Inquiry
- How to add profiles: [CHAMPS Navigation](#), slides 140-146
How to Verify Beneficiary Eligibility

Steps within CHAMPS
- Click the Member tab
- Select the Eligibility Inquiry option
Select the Filter By criteria from the drop-down selection.

Inquiry start date and end date default to the system date/current date. If you want another date click on the calendar option to change.

Click Submit.
Click the hyperlink PHIP-HMP within the Benefit Plan ID
Benefit Plan ID and Description are provided
Click close to return back to the Benefit Plans List
Click on the CHAMPS Provider ID hyperlink 2841979 to determine what managed care plan the beneficiary is enrolled in.
- Provider Information Summary is provided for the managed care
- Click close to return back to Benefit Plans List
- Provider Information Summary is provided for a different managed care
- Click close to return back to Benefit Plans List
Click the hyperlink, Click to View Service Types, this will show available benefits within the benefit plan.
The available benefits will display

Please read Policy Bulletin [MSA 15-49](#) for further Cost-Sharing Limits information

Further [Co-Pay Requirements](#) consistent with Policy Bulletin [MSA 17-02](#)
The Healthy Michigan Plan beneficiaries enrolled in a health plan are not responsible for co-pays at the point of service as long as the service is covered by the health plan. **Policy Bulletin MSA 15-49**
Verifying Third Party Liability Information

Steps within CHAMPS
If a beneficiary has a primary payer on file for the date of service being checked, the Commercial/Other will be Y.

Click the Commercial/Other Hyperlink to view the primary payer on file.
The primary payer information will display, including the coverage type, group number, policy number, date updated and begin and end dates.
Specific Benefit Plan Assignments

Medical Assistance (MA)
Children’s Special Health Care Services (CSHCS)
Dental
Emergency Services Only (ESO)
Prepaid Inpatient Health Plan (PIHP)
Spend-down
Specific Benefit Plan Assignments - MA

- For a full list of Benefit Plans please locate the [MI Medicaid Provider Manual](#), Chapter Beneficiary Eligibility, Section 2.1 Benefit Plans.
- Medicaid Medical Assistance can be seen as:
  - MA
  - MA-HMP
  - MA-MC
  - MA-HMP-MC
- Members are generally assigned to this benefit plan upon approval of their eligibility information and remain active even if eventually assigned to MA Managed Care [MA-MC]. Once assigned to a Managed Care Organization, the health plan is the primary payer.
- If a beneficiary has MA-MC coverage will also show MA.
- If beneficiary has MA-HMP-MC coverage will also show MA-HMP.
Specific Benefit Plan Assignments - CSHCS

- MI Medicaid Provider Manual, Chapter Children’s Special Health Care Services, Section 1 – General Information.
- CSHCS: This benefit plan is designed to find, diagnose, and treat children under age 21 with chronic illness or disabling conditions. Persons over age 21 with chronic cystic fibrosis or certain blood coagulation blood disorders may also qualify. Covers services related to the client's CSHCS-qualifying diagnoses. Certain providers must be authorized on a client file.
- CSHCS identifies children with special health care needs when the child appears to have a condition that CSHCS may cover.
• CSHCS does not cover behavioral, developmental or mental health conditions.

• The child’s pediatric subspecialist submits medical reports to CSHCS for determination of medical eligibility.

• When the child does not have a pediatric subspecialist and there is no other option to obtain a medical report (i.e., private insurance, Medicaid, etc.), CSHCS pays for a diagnostic evaluation of medical conditions that are likely to be covered by CSHCS.

• Eligibility is determined based upon medical circumstances and not on financial circumstances.
When a provider’s NPI is not authorized as a servicing provider for the beneficiary, the above error message will show. Please contact the county analyst for approval.

THIS NPI IS NOT LISTED. SEE CSHCS GUIDELINES.
Specific Benefit Plan Assignments - Dental

- HK-Dental: The Healthy Kids Dental program is a selective contract between the Michigan Department of Health and Human Services (MDHHS) and Delta Dental Plan of Michigan to administer the Medicaid dental benefit in selected counties to beneficiaries under the age of 21.
- Dental services for Fee-For-Service beneficiaries with a MA benefit plan are billed to Medicaid.
- Dental services may be provided to all Medicaid beneficiaries include emergency, diagnostic, preventive, and therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or supportive structures.
- Providers with a beneficiary in a Manage Care need to check with the health plan to determine the appropriate plan to bill.
- Example of HK-Dental plan for a beneficiary under the age of 21
Specific Benefit Plan Assignments - ESO

- Benefit Plans include:
  - HK-EXP-ESO: Benefits mirror Medical Assistance Emergency Services Only (MA-ESO). Children who do not meet the Medicaid citizenship requirements to be eligible for full Medicaid may be eligible for Emergency Services Only (ESO). This benefit plan is funded by CHIP.
  - MA-ESO: Individuals who do not meet the Medicaid citizenship requirements to be eligible for full Medicaid may be eligible for Emergency Services Only (ESO).
  - MA-HMP-ESO: Individuals who do not meet the Healthy Michigan Plan citizenship requirements to be eligible for full coverage may be eligible for Emergency Services Only (ESO).
Specific Benefit Plan Assignments – ESO (cont.)

- For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:
  - Place the person’s health in serious jeopardy, or
  - Cause serious impairment to bodily functions, or
  - Cause serious dysfunction of any bodily organ or part.
Specific Benefit Plan Assignments - PIHP

- PIHP: This benefit plan provides specialty behavioral health services for individuals enrolled in MA.
- PIHP-HMP: This benefit plan provides managed care specialty behavioral health services for individuals enrolled in the Healthy Michigan Plan.
- Pursuant to Michigan’s Medicaid State Plan and federally approved 1915(b) waiver and 1915(c) Habilitation Supports Waiver (HSW), community-based mental health, substance abuse and developmental disability specialty services and supports are covered by Medicaid when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP).
  - A PIHP may be either a single community mental health services program (CMHSP), or the lead agency in an affiliation of CMHSPs approved by the Specialty Services Selection Panel.
- The PIHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and all of those specialty services/supports included in the manual.
Specific Benefit Plan Assignments – PIHP (cont.)

- Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program.
  - The FFS benefit allows 20 combined outpatient behavioral health visits in a 12-month period by all FFS providers.
- All admissions and transfers to distinct-part psychiatric units or freestanding psychiatric hospitals and all continued stays in a psychiatric unit/hospital. (Authorization must be obtained through the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).)
- Services provided to persons with developmental disabilities and billed through the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).
- Please reference the Practitioner Chapter, Section 14 and Behavioral Health and Intellectual and Development Disability Supports and Services Chapter of the Medicaid Provider Manual for further PIHP information.
Specific Benefit Plan Assignments – Spend-down

- Spend-down: If the individual's net income is over the Medicaid limit, the amount in excess is established as a "spend-down amount." In order for the person to qualify for Medicaid during the months, he/she must incur medical bills equal to the spend-down amount. Medicaid will pay expenses incurred above this amount. If a group member is liable for bills incurred before the spend-down period began, these bills can be used to meet the spend-down.

- MA (Benefit Plan will be on file once the spend-down is met.)
Medicaid Provider Trainings

Upcoming Trainings
Upcoming Trainings

- March 7, 2017 – Practitioner 101 Virtual Training (10:00-11:00am)
- March 21, 2017 – SNF Billing Virtual Training (10:00-11:00am)
- March 28, 2017 – Document Management Portal (DMP) Virtual Training (10:00-11:00am)
- April 6, 2017 – Level of Care Determination (LOCD) Virtual Training (10:00-11:00am)
- To see more trainings please visit the Medicaid Provider Trainings site.
- Recordings of past presented trainings are also available and updated frequently on the Medicaid Provider Training site.
- If you have suggestions for trainings please email: ProviderOutreach@Michigan.gov
Provider Resources

- **MDHHS website:** [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders)

- **We continue to update our Provider Resources, just click on the links below:**
  - Listserv Instructions
  - Medicaid Alerts and Biller “B” Aware
  - Quick Reference Guides
  - Update Other Insurance NOW!
  - Medicaid Provider Training Sessions

- **Provider Support:**
  - [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov) or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program.