Ambulance Billing Session

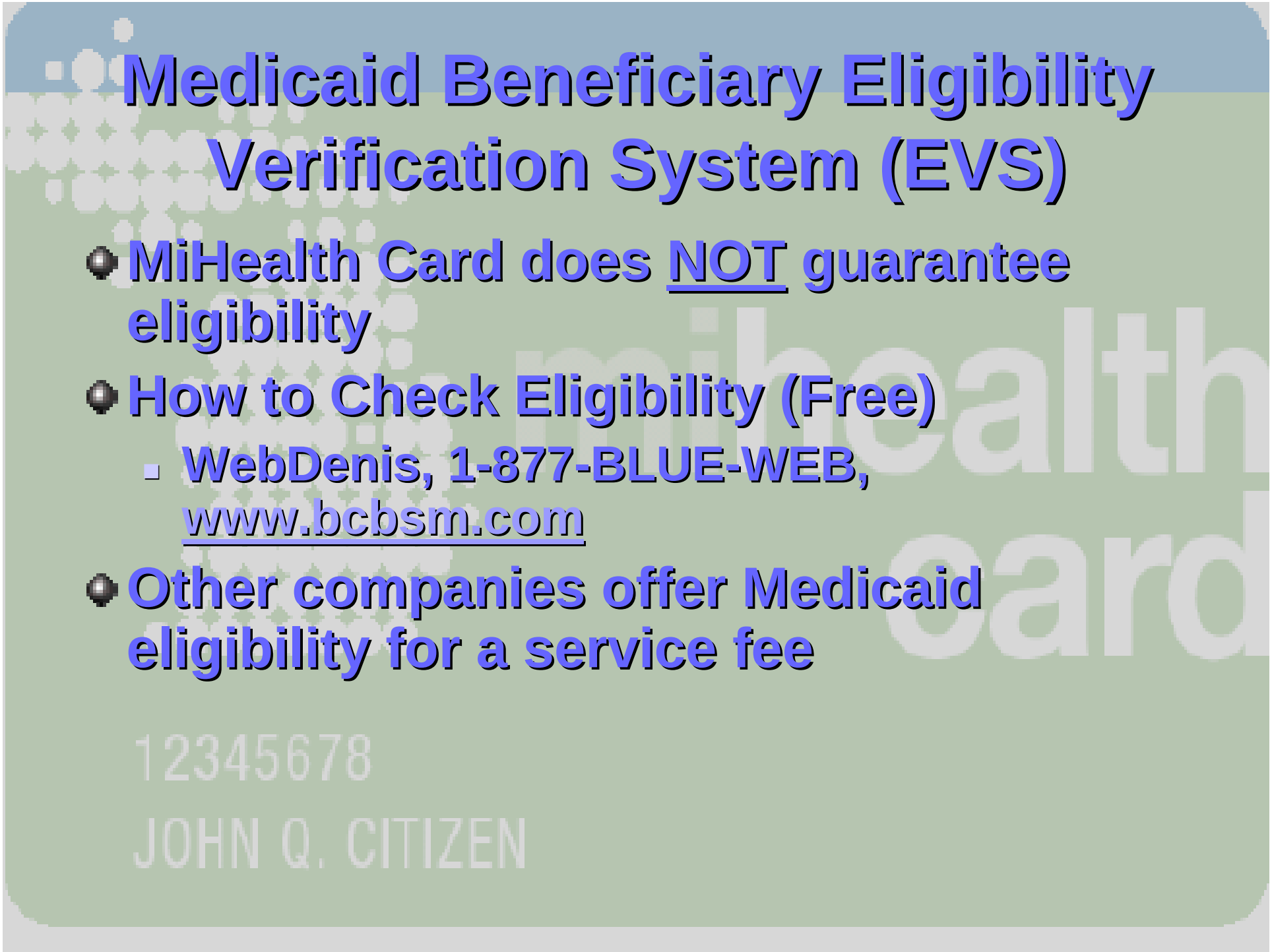
MDCH, Medical Services Administration

Provider Outreach & Education

Beneficiary Eligibility

Medicaid Beneficiary Eligibility Verification System (EVS)

- MiHealth Card does NOT guarantee eligibility
- How to Check Eligibility (Free)
  - WebDenis, 1-877-BLUE-WEB, www.bcbsm.com
- Other companies offer Medicaid eligibility for a service fee



Michigan Medicaid Programs

- Straight Michigan Medicaid
  - Title XIX
  - Fee For Service (FFS)
- Children's Special Healthcare Services (CSHCS)
  - Title V
  - Provides certain approved coverage for qualifying conditions: Cystic Fibrosis, Blood Coagulating Disorders, etc.

Michigan Medicaid Programs

- ABW (Adult Benefit Waiver)
- Maternity Outpatient Medicaid Services (MOMS)
  - Pregnant women only
  - Covers all medical needs related to pregnancy
- Healthy Kids
  - Low-Income qualifying children under age 19
- Plan First
  - Family planning only

Adult Benefits Waiver

- Provides basic health insurance coverage to low-income childless adults
- Limited Medicaid Coverage
  - Refer to the ABW Section of the Manual
- Level of Care (LOC) 11
  - ABW beneficiaries enrolled in County Health Plan
- No LOC code is used to identify the FFS ABW beneficiary

National Provider Identification (NPI)

REPORTING PROVIDER NPI

A Type 1 (Individual) NPI is the number associated with an individual healthcare professional (e.g., MD, DDS, CRNA, etc.)

- A Type 2 (Group) NPI is the number required for organizations (such as clinics, group practices, and incorporated individuals) who provide healthcare services and receive payment.
  - The Group NPI must be reported in the billing provider loop or field
  - Do not enter the Type 2 (Group) NPI as the rendering provider

Note: A claim will reject if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields

REPORTING PROVIDER NPI

- **REFERRING PROVIDER** (laboratory and consultation services)
  - MDCH does not require the referring provider to be enrolled with the program, but a valid NPI must be reported
- Electronic
  - Loop 2310B, Segment NM1
- Reported in Box 17 – 17b
  - Referring Provider Name in Box 17
  - Referring NPI in Box 17b

Prior Authorization

Prior Authorization (PA)

- Refer to specific codes for PA
- If PA is needed, contact:
  - MDCH Prior Authorization Division
    PO Box 30170
    Lansing, MI 48909
  - 1-800-622-0276
  - Fax 517-335-0075
- Report the 10-digit PA in Box 23

  Loop 2300 Qualifier G1
- Prior Authorization (PA) Number
  - If billing for clinical lab services, the CLIA registration number must be reported in this field.
    - The number is a 10-digit number with "D" in the third position

Electronic Billing

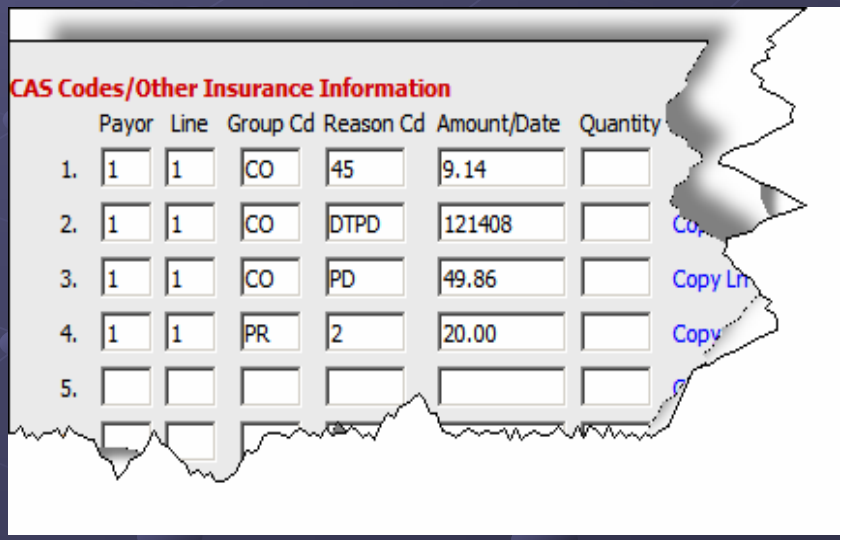
Electronic Billing

- NM1*85 is the Group/Billing NPI information (all claims)-Loop 2010AA (box 33a)
- NM1*82 is the Individual/Rendering NPI information (professional claim)- Loop 2310B (box 24)
- NM1*DN is the Referring NPI information (professional claims) – Loop 2310A (box 17a)
- NM1*FA is the Service Facility NPI information (professional claims) – Loop 2310D
- NM1*77 is the Service Location NPI information (professional claims) – Loop 2310D

Common Reason Codes (CAS Codes)

- 1 = Deductible Amount
- 2 = Coinsurance Amount
- 3 = Co-pay
- 45 = Contractual amount
- 96 = Non-covered charges

Complete list:
www.wpc.edi.com/codes



Electronic Remittance Advice - 835

- 835 submitted to requested billing agent through Data Exchange Gateway (DEG)
- First time designations must be done in CHAMPS. **The 835 is sent only ONCE per Tax ID**
- Change Request form may be found at www.michigan.gov/tradingpartners >> Policy and Forms
  - 835/277U Change Request Form
- Provider WILL continue to receive paper RA's as well as the 835
- Note: When CHAMPS is live, paper RA will discontinue unless provider has designated a RA address

Electronic Billing

- Information found at: www.michigan.gov/tradingpartners
- Companion Guides
- B2B Testing Information
- Approved Billing Agents (Vendor)
- Send all Electronic Billing questions to AutomatedBilling@michigan.gov

Remittance Advice

Paper Remittance Advice (RA)

- RAs show the status of the claim
  - Paid (MA, CC, ABW, etc.)
  - Pended (PEND)
  - Rejected (REJ)
- Currently RAs are grouped by Provider ID
- RAs will be sent to individual Providers

Information on the RA

- Claim Reference Number (CRN)
- Provider Reference Number or Account Number
- Date of Service (DOS)
- Procedure Code
- Quantity
- Amount Billed
- Amount Approved
  - Note: Amount owed to provider due to MDCH signifies take back with negative payment
- Explanation Codes

Paid Claims

- Source/Status = MA, CC, ABW, CO-DED, etc.
- **.00 MA is considered an approved/paid claim**
- Medicaid Reimbursement
  - Lesser value of Providers Charges or Medicaid Fee Screens minus Other Insurance Payments
  - Medicaid's payment is **Payment in FULL**
  - Providers may **NOT** bill beneficiary for additional charges

Pended Claims

- Source/Status = PEND
- Review Edit Information
- Claim is still active in Medicaid system
- Do NOT rebill a correctly pended claim
  - Only rebill a pended claim when you know the claim will reject due to billing errors

Rejected Claims

- Source/Status = REJ
- Review Edit Information
- Rejected claims are no longer active in Medicaid System
- If applicable, fix any errors and rebill as a clean claim

Completing the UB-04

Completing UB-04

Report

- Revenue code 054X (0540, 0545, or 0546)
- Taxonomy code must be reported along with the NPI to designate ambulance (e.g. land, air, or by water)
  - Electronic- Report the valid taxonomy code (e.g. **341600000X**) in loop 2000A of the 837 4010A1
- Procedure code for ambulances service from wrap around list with appropriate modifier

Completing UB-04

Report

- Date of service for each claim line
- A one-way ambulance trip-reported on two separate lines:
  - one line represents the ambulance service provided
  - one line represents the mileage
- The number of units reported for the revenue line reflecting each ambulance trip should always equal "1“
  - mileage code –report whole miles the beneficiary was transported
- The appropriate origin and destination modifier

Completing the CMS-1500

Completing CMS-1500

Place of Service (24B) -

- Report 2-digit place of service code from the list of CMS (e.g. 12, 41 or 42)

Charges (24F)-

- Report the usual and customary (U&C) fee charged to the public.
- If the public receives a service without charge, an ambulance provider cannot bill MDCH for the same service.
- If one charge is made to tax-paying residents in a given township, and a higher charge is made to nonresidents, the same charge formula should be applied for Medicaid beneficiaries.
- When billing Medicaid for services covered by Medicare, report the Medicare allowable amount (paper only)
- When billing Medicaid for services covered by other third party carriers who have participating provider agreements in effect, report the carrier's allowable amount

Completing CMS-1500

Days or Units (24G)-

- Enter the number of days or units. If only one service is performed, the number "1" must be entered. Some services require the actual number or quantity billed be clearly indicated on the claim form (e.g., mileage)

Service Facility Location (32)-

- Enter the name, address, city, state and zip code of the location where the services were rendered (e.g. office, hospital, clinic, laboratory or facility)

Secondary/Tertiary Claims

- For Medicaid Secondary Claims:
  - *Primary* Insurance is to be reported in Box 11a – 11d
- For Medicaid Tertiary Claims:
  - *Primary* Insurance is to be reported in Box 11a – 11d
  - *Secondary* Insurance is to be reported in Box 9a – 9d
- EOB is not required for electronic claims
- Remember Medicaid is always the payer of last resort

Comments

- Reported in Box 19
- Use for comments that are necessary for claims processing
  - **Ex: Returning money (Take backs)**
- Do not use unnecessary comments
- If billing electronically and comments are needed, make sure billing agent is forwarding comments to Medicaid (Loop 2300, Segment NTE)
- Example = CONSENT ON FILE
  - Example = voids, replacement bills, OI documentation
  - Example = Documentation EZ Link

Top Edits
(Professional & Institutional)

Edit 552 (Professional)

- The claim is a duplicate of a previously paid claim.
- Resolution: The Claim Reference Number, line number, and payment date of the paid claim are shown. (If the Claim Reference Number following Explanation Code 552 is the same as the number assigned to this claim in the left column on the Remittance Advice, duplicate services are billed on this claim.)

Edit 492 (Professional & Institutional)

- The beneficiary was not eligible for CSHCS, Medicaid, or ABW coverage on the DOS. The date(s) and beneficiary ID number should be verified. If appropriate, the claim should be corrected and re-billed. If the data is correct, the service must not be re-billed.
- RESOLUTION:
  - Check Eligibility
  - Beneficiary may have Medicaid Deductible
  - Medicaid Manual
    - Beneficiary Eligibility

Edit 492 (Continued..)

Medicaid Deductible (formerly Spendown)

- The Beneficiary is not eligible for Medicaid until they incur monthly medical expenses
- Medicaid Deductible beneficiaries do NOT have Medicaid coverage when the deductible has not yet been met
- Providers may bill the patient until the Medicaid eligibility is on the DHS file

Edit 492 (Continued..)

Medicaid Deductible

- Provider check eligibility
- Beneficiary has a Scope/Coverage Code of 20
- Provider may bill beneficiary or deny services until beneficiary has paid for services
- Beneficiary then takes the receipt or bill to their caseworker to have the information added to the DHS file
- When the total amount of receipts or bills is equal to the Medicaid deductible, the beneficiary will then be Medicaid eligible

Edit 092 (Professional)

- The procedure code is invalid, OR the combination of the type of service code and procedure code is invalid, OR the procedure code is incorrect for the provider OR for Outpatient Hospital, the required HCPCS code is missing.
- RESOLUTION: The provider should verify the procedure code, type of service code, and provider type code. The claim should be corrected and rebilled.

Edit 092 (Continued..)

- The most common procedure codes:
- 0A0422
- 0A0888
- 0A0434
- 0A0424
- 0A0130
- 0S0209

Edit 105 (Professional)

- This service may have a comprehensive/component or a mutually exclusive relationship with another service billed for the same date.
- RESOLUTION: Billing these combinations is unnecessary and delays payment

Edit 105

- The most common procedure codes:
- 0A0429 0A0428
- 0A0427 0A0428
- 0A0427 0A0426

Edit 730 (Professional)

- Mutually exclusive services have been billed separately and payment is not allowed.
- RESOLUTION: These procedures must be combined and re-billed on one claim line, using the appropriate procedure code.

Edit 132 (Professional)

- The disposition of this claim/service is pending further review.
  - When modifier 22 reported, the claim will be pended to be manually reviewed by claim processing. Report/remarks required.

Edit 262 (Professional)

- The beneficiary data on the Eligibility Verification System indicates other insurance.
- RESOLUTION:
- Bill primary insurance 1st
- To update insurance information send email to TPL_health@michigan.gov with "OI" as subject

Edit 262 (Continued..)

- The beneficiary data on the EVS system indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.
- RESOLUTION:
  - All Other Insurance on EVS for the DOS MUST be reported on the claim.
  - Secondary/Tertiary Claims can be sent electronically without EOB attachments.

Edit 269 (Professional & Institutional)

- The claim is being manually reviewed for possible change in other insurance status.
- RESOLUTION:
  - Institutional –
    - Non covered services- report Occurrence code 24 & date.
    - No coverage on DOS- report Occurrence code 25 & date.
  - Professional –
    - Report primary in Box 11(a-d)
    - Report 2ndry in Box 9 (a-d)

Edit 093 (Institutional)

- The procedure code or the combination of the modifier and procedure code is not covered on the date of service. The provider should verify the procedure code, modifier, and date of service.
- Provider should also verify the billing procedure with current manual material for possible changes. The claim should be corrected and re-billed.

Edit 093 (Continued..)

- RESOLUTION:
  - The HCPCS is a valid HCPCS, but it is not covered by Medicaid on DOS
  - Check the Procedure Code, Modifier and DOS
  - Medicaid Website
    - Provider Specific Information
- The most common procedure codes
  - 0A0394
  - 0A0434

Edit 423 (Institutional)

- The procedure code cannot be billed by the Outpatient Hospital.
- Resolution: The provider must rebill using the correct claim form.

Edit 023 (Institutional)

- The beneficiary was not eligible for Medicaid or Adult Benefits Waiver Program coverage on the date(s) of service.
- Resolution:
  - Check coverage for DOS.
  - Contact beneficiary's DHS caseworker in the event of discrepancy

Edit 104 (Institutional)

- If billing **A0420** the remarks section report:
  - **Total** length of wait including the first 30 min.
  - **Physician's name** that ordered the wait
  - **Reason** for the wait
- If billing **A0999 (NOC)** report:
  - **The description in the remark**
  - **Do not bill for**
    - **Waiting time**
    - **Patient refused transport**
    - **Base Rate**

Provider Tips

Tips

- MDCH reimburses ambulance when:
  - Medical/Surgical or psych emergencies exist
  - No other effective mode of transportation for medical treatment can be used
- A physician must order all covered services
  - Physician order must include:
    - Beneficiary Name and ID number
    - Explanation of ambulance need
    - Signature of physician and NPI
  - Emergency services do not require physician order

Tips

- Reimbursement
  - MDCH will reimburse for the coinsurance and deductible amounts on Medicare approved claims even if Medicaid does not normally cover services
  - Check fee screens for reimbursement limitations on Medicare approved claims

Tips

- Fixed Wing Air Ambulance
  - Prior Authorization (PA) is required
  - PA must include:
    - Transport, including ancillary services, ordered by physician
    - Written physician order
    - Transport by ground would endanger beneficiary's life
    - Care and medical services cannot be provider by local facility
    - Transport is for medical or surgical procedures

Tips

- Helicopter Air Ambulance
  - MDCH will cover Helicopter services if:
    - Time/Distance in ground ambulance would be hazardous to patient
    - Care and medical services cannot be provided by local facility
    - Transport is for medical or surgical procedures
  - Coverage includes helicopter base rate, mileage, and waiting time

Tips

- Base Rate
  - May bill one base rate procedure code
    - Basic Life Support (BLS) Non-emergency
    - BLS Emergency
    - Advanced Life Support (ALS) Non-emergency
    - ALS 1 Emergency
    - ALS 2
    - Neonatal Emergency Transport
    - Helicopter Air Ambulance
    - Fixed Wing Air Ambulance Transport
  - Medicaid will only pay for level of service required
  - All services rendered are covered
  - Mileage is billed separately

Tips

- Mileage is reimbursable when:
  - Transport occurs
  - Loaded mileage only
  - Billed with appropriate modifier
    - Do not report modifier 22
  - If mileage is greater than 100 miles, enter the origin and destination addresses in the Remarks session

Tips

- Waiting Time
  - Time deemed necessary to wait while patient is being stabilized
  - Reimbursable after first 30 minutes
  - Maximum wait time is 4 hours

Tips

- Neonatal coverage includes:
  - Base rate
  - Loaded mileage
  - Waiting time that exceeds 30 minutes
  - Intensive care transport to approved designate intensive care units
  - Return trip of a newborn from a regional center to a community hospital (physician ordered)
- Hospital medical team must accompany newborn in the ambulance

Tips

- Non-emergency transport
  - Claim may be made when provided in a licensed BLS or ALS vehicle
  - Physician can write a single prescription for a beneficiary with a chronic condition to a planned treatment that covers 1 month of treatment
  - Prescription must contain:
    - Type of transport
    - Why other means of transport couldn't be used
    - Frequency
    - Origin & Destination
    - Diagnosis & Medical necessity
  - Non-emergency transport in Medi-van or wheelchair-equipped car is not covered for ambulance providers

Tips

- Multiple transports per beneficiary
  - Same date of service is covered when:
    - Beneficiary received different service on each transport
    - Beneficiary received same service on each transport
    - Services duplicated from multiple transports can be combined and billed on same line
    - Services not duplicated are billed on separate lines
    - Remarks section must detail
      - Number of transports
      - Origin and Destination locations
      - Ambulance requestors name
      - Reason for multiple transports on same day
      - Number of times base rate was provided
      - Reason for transport other than diagnosis

Tips

- Pronouncement of Death
  - If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment is made at BLS rate with no mileage.

Tips

- Ambulance coverage exclusions:
  - Medi-Car/Van or wheelchair transports
  - Transport to funeral home
  - Trips that could be provided at beneficiary's location
  - Transportation of beneficiary pronounced dead before the ambulance was called
  - Round trips from/to hospital where beneficiary is an inpatient
  - Transport of inmates to/from correctional facility
  - Transports that are not medically necessary

Tips

- Wait Time
- The appropriate number of time units must be reflected in the Quantity field.
  - One time unit represents each 30 minutes of waiting time after the first 30 minutes
  - No additional payment is made for the first 30 minutes of waiting time (i.e., total waiting time of 1 hour 30 minutes = 2 time units)
- The Remarks section or claim attachment must include the following information:
  - Total length of waiting time, including the first 30 minutes
  - Name of the physician ordering the wait; and reason for the wait

Tips

- **Mileage**
  - When billing a mileage code, enter the number of whole miles the beneficiary was transported in the quantity field
  - When billing for mileage greater than 100 miles, enter the origin and destination addresses in the remarks section
  - Do not use decimals

Replacement and Void Claims

Replacement/Void Claim Tips

- Do not submit replacement or void/cancel claim when the entire claim rejected. If the claim is rejected, re-submit the *entire* claim
- Be sure when claim replacing or voiding to use the ***MOST RECENT APPROVED CRN!*** Claim remarks are always required to explain why the claim is being replaced or void/canceled
- Only approved claims can be replaced or void/canceled. If the approved amount on any line of a claim states anything other than PEND or REJ, then the claim is considered approved

Replacement Claims

- Correct Claim Completion instructions apply
- Replacement claim MUST have same 10 digit-Beneficiary ID and Provider NPI as original claim
- Resubmit claim in its entirety in the same manner it should have been submitted originally
- Resubmission Code = 7
  - Field 22 or Loop 2300 CLM05-3
- Original 10-digit CRN
  - Field 22 or Loop 2300 REF with Qualifier F8
- Replacement Claim will completely replace original claim

Replacement Claims

- Submit a replacement claim when:
  - All or part of a claim was paid incorrectly
  - All or part of a claim was billed incorrectly
    - i.e. Incorrect Units, Charges, Procedure Code, Date of Service, etc.
- Always use the CRN from the last approved claim when replacing or void/canceling a claim

Void/Cancel Claims

- Correct Claim Completion Instructions Apply
- Must have same Beneficiary ID and Provider NPI as Original Claim
- Complete one service line with 0 billed
  - Entire original payment will be debited
- Resubmission Code = 8
  - Field 22 or Loop 2300 CLM05-3
- Original 10-digit CRN
  - Field 22 or Loop 2300 REF with Qualifier F8
- Void Claim will completely void original claim

Void/Cancel Claims

- Submit a Void/Cancel Claim when:
  - A claim is paid under the wrong provider ID or beneficiary ID
    - If claim was billed under the wrong provider ID or beneficiary, the same provider ID and beneficiary ID must be used on the void claim. A new claim can be submitted for the correct provider ID/beneficiary ID
  - The claim was never meant to be submitted
  - A duplicate claim has paid
- Always use the CRN from the last approved claim when replacing or void/canceling a claim

Third Party Liability (TPL)

Other Insurance Tips

- To reflect a Medicare non-covered service with Medicaid use Modifier GY
- A beneficiary does not have other insurance, but Medicaid has it on the beneficiary's file
  - Report OI in Box 11, Comments Box 19
  - Contact TPL to have OI Removed, when notified, bill claim without OI

Third Party Liability (TPL)

- To correct or update Other Insurance (OI) information on the TPL file, submit documentation to:
  - Fax (517) 346-9817
  - Email: TPL_Health@michigan.gov
- Make sure to include:
  - Subject Line: “OI”
  - DOS, Beneficiary ID, Contract/Policy number, Termination Date, etc.
- An EOB from the other carrier is the preferred documentation.

Modifiers

Modifiers

Modifier	Description
D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Non hospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

Modifier	Description	Special Instructions
GM	Multiple patients on one ambulance trip	Enter on the transport service line for second or subsequent patient when more than one patient is transported. Reduces reimbursement for the second or subsequent patient transported. Do not report for the first patient.

MDCH Contacts

MDCH Medicare Buy-In Unit

Responsible for:

- Processing Medicare premium payments for eligible Medicaid beneficiaries
- Other Insurance (OI) coding for Medicare on the Medicaid system
- Alien information for Medicaid beneficiaries that are age 65+, must have the date of entry forwarded to the Buy-In Unit if the beneficiary has not been in the US for over 5 consecutive years

MDCH Medicare Buy-In Unit

- This resource is for ***Providers Only***
- Makes payment to CMS for Medicare/Medicaid beneficiaries that cannot afford the Medicare premium amounts
- Dept. of Human Services (DHS) determines if the beneficiary is eligible to have the Medicare premium paid for by the State of Michigan

MDCH Medicare Buy-In Unit

- Contact the MDCH Buy-In Unit if the Medicare eligibility information given by MDCH does not match the Medicare eligibility information given by Medicare
- The beneficiary must first be enrolled with Medicare Part A or B

MDCH Medicare Buy-In Unit (continue..)

Phone: 517-335-5488

Fax: 517-335-0478

Email: BuyInUnit@michigan.gov (preferred)

- The Buy-In Unit is not able to address questions from beneficiaries. Refer beneficiaries to their caseworker or the Beneficiary Helpline (1-800-642-3195) or MMAP (1-800-803-7174)

PERM

Payment Error Rate Measurement PERM

- PERM is a regulation issued by CMS as a result of the 2002 Improper Payments and Information Act (IPIA)
- PERM measures improper payments for State Medicaid programs and State Children's Health Insurance Programs (SCHIP)
- A random sample of paid claims are selected for review
- MDCH will publish a bulletin soon regarding PERM

How Does PERM Work?

- **Livanta LLC** has been selected as the National contractor that will contact providers to collect medical record documentation pertinent to the selected paid claims
- Providers **must** submit the requested medical record documentation with 60 days
- Failure to comply with the request(s) is considered payment error. Michigan Medicaid will incur a penalty and may recoup the payments that were made on the selected claims from the providers

Medicaid Website

www.michigan.gov/mdch

- Provider Specific Info (Rates)
- Provider Manual
- Provider Tips
- Biller B Ware
- CHAMPS

MDCH - Michigan Department of Community Health - Microsoft Internet Explorer

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MDCH

Department of Community Health

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Michigan.gov

The Official State of Michigan Website

Search GO

Departments/Agencies

Online Services

Surveys

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Quick Links

- News Releases
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- Health Information Technology (HIT) Commission
- Office of Long-Term Care Supports and Services
- Influenza in Michigan
- Informed Consent for Abortion
- Find Shortcuts to MDCH Web Topics
- MDCH Brochures Available for Download
- Emerging Diseases
- Might I be eligible for benefits? Click here

Birth, Death, Marriage and Divorce Records

Physical Health & Prevention

Pregnant Women, Children & Families

Mental Health & Substance Abuse

Health Care Coverage

Statistics and Reports

Providers

Inside Community Health

Health Systems & Health Profession Licensing

michigan steps up

michiganstepsup.org

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> Webcasts and Podcasts From the Director

The Michigan Department of Community Health has added podcasts as a new feature on the Web site. MDCH wants to further communicate our health message to you.

All podcasts will feature tips and information on various topics such as the benefits of maintaining a healthy heart, visiting a doctor and dentist routinely, eating the right foods and exercising.

The podcasts will be updated regularly to accompany various events and news related to health issues in Michigan. Please, enjoy this new tool as you take charge of your health.

MDCH - Providers - Microsoft Internet Explorer

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Google Search Bookmarks Find Check AutoFill Sign In

Michigan.gov Home | MDCH Home | Online Services | Sitemap | Contact MDCH | Search GO

Providers

- HIPAA
- Health Professional Shortage Area
- Institutional Review Board
- State Loan Repayment Program
- Lab Services
- Public Health Preparedness
- Communicable & Chronic Diseases
- Departmental Forms
- Community Mental Health Services
- Certificate of Need
- Toxic Substances
- Substance Abuse Providers

Birth, Death, Marriage and Divorce Records

Physical Health & Prevention

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Providers

CHAMPS
Community Health Automated Medicaid Processing System

This website offers information for service providers, managed care organizations and trading partners related to healthcare programs administered by the Michigan Department of Community Health. Programs include Medicaid, Children's Special Health Care Services, Children's Waiver, Adult Benefits Waiver, MOMS, and Plan First!.

The website has been organized to assist users to easily locate pertinent information. For additional assistance providers and trading partners may contact Provider Support at 1-800-292-2550 or ProviderSupport@michigan.gov.

Providers

Managed Care

Trading Partners

Departments/Agencies
Online Services
Surveys
RSS Feeds

Quick Links

- News Releases
- Careers & Internships
- Finding Free or Low-Cost Health Care
- Health Information Technology (HIT) Commission
- Careers & Internships
- Office of Long-Term Care Supports and Services
- Influenza in Michigan
- Informed Consent for Abortion
- Find Shortcuts to MDCH Web Topics
- MDCH Brochures Available for Download
- Emerging Diseases
- Might I be eligible for benefits? Click here to find out

Quick Links

Trusted sites

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Google Search Bookmarks Find Check AutoFill Sign In

- Community Mental Health Services
- Certificate of Need
- Toxic Substances
- Substance Abuse Providers

Birth, Death, Marriage and Divorce Records

Physical Health & Prevention

Pregnant Women, Children & Families

Mental Health & Substance Abuse

Health Care Coverage

Statistics and Reports

Inside Community Health

Health Systems & Health Profession Licensing

Support at 1-800-292-2550 or ProviderSupport@michigan.gov.

HOT TOPICS

- CHAMPS

Medicaid is a federal and state funded health care program that provides comprehensive health care coverage for the medically indigent.

Information about **Mental Health & Substance Abuse**

Information about **Children's Special Health Care Services** and the Children with Special Needs Fund

Other Health Care Programs includes Adult Benefits Waiver, Healthy Kids Dental, MI Choice, MOMS, Plan First!, PACE

Provider Enrollment
Access provider enrollment forms and information, as well as instructions for initiating Electronic Funds Transfers (EFT)

Eligibility Verification System
Access information and options available related to verfying beneficiary eligibility.

Trusted sites

MDCH - - Microsoft Internet Explorer

File Edit View Favorites Tools Help

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Address http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546-153200--,00.html Go Links SnagIt

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please email MSAPolicy@michigan.gov .

HOT TOPICS

- CHAMPS
- Biller "B" Aware
- Provider Tips
- Documentation EZ Link

Get information about **Policy and Forms** like the Medicaid Provider Manual, draft and final policy bulletin, etc.

In **Billing and Reimbursement**, information necessary for claim submission, including billing tips, provider-specific procedure code databases (including fee screens), electronic billing information, Sanctioned Provider list, Beneficiary Co-Payment Requirements, Third Party Liability, etc.

Trusted sites

MDCH - - Microsoft Internet Explorer

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Providers

- HIPAA
- Health Professional Shortage Area
- Institutional Review Board
- State Loan Repayment Program
- Lab Services
- Public Health Preparedness
- Communicable & Chronic Diseases
- Departmental Forms
- Community Mental Health Services
- Certificate of Need
- Toxic Substances
- Substance Abuse Providers

Birth, Death, Marriage and

BILLING & REIMBURSEMENT

Electronic Billing
This link will provide important information and documents for all your electronic billing needs. Please view the B2B instructions and all Trading Partner information.

Provider Specific Information
Related to billing and reimbursement for services to Medicaid, CSHCS, ABW, and MOMS beneficiaries.

Third Party Liability
Coordination of benefits, casualty, manual, and related links.

List of Sanctioned Providers
Lists providers excluded from Medicaid

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http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html

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Web Search Bookmarks Settings Mail News Sports My Yahoo! Games Anti-Spy

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PROVIDER SPECIFIC INFORMATION

Click on a provider category below for covered procedure codes, fee screens and other information related to billing and reimbursement for services to Medicaid, CSHCS, ABW, and MOMS beneficiaries.

For fee screens before 2003, email msapolicy@michigan.gov .

Ambulance

Inpatient Hospital

Children's Special Health Care Services

Outpatient (hospital, freestanding ESRD facilities, CORFs, rehab agencies, outpatient therapy)

Clinical Laboratory

Maternal Infant Health Program

Dental

Medical Suppliers / Orthotists / Prosthetists, DME

Providers

- HIPAA
- Health Professional Shortage Area
- Institutional Review Board
- State Loan Repayment Program
- Lab Services
- Public Health Preparedness
- Communicable & Chronic Diseases
- Departmental Forms
- Community Mental Health Services
- Certificate of Need
- Toxic Substances
- Substance Abuse Providers

Birth, Death, Marriage and Divorce Records

Physical Health & Prevention

Pregnant Women, Children & Families

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Ambulance

Databases 2006 April] Data] 2006 Jan] Data] 2005 May] Data] 2004 April] Data] 2004 Jan] Data] 2003 Fee] Data] Instructions

Emergency Transports Diagnosis Codes Database

NOTE: Effective for dates of service (DOS) on/after April 1, 2007 Hospital-Owned Ambulance services are reimbursed under the MDCH Outpatient Prospective Payment System (OPPS). While fees indicated in the MDCH Ambulance Services Database apply to ambulance services, claims submitted by hospital-owned ambulance providers for DOS on/after April 1, 2007 must be submitted on the institutional claim format.

- OPPS Wrap Around Code List - 2009 April] Data] 2009 Jan] Data] 2008 Oct] Data] 2008 July] Data] 2008 April] Data] 2008 Jan] Data] 2007 Oct] Data] 2007 July] Data] 2007 April] Data]
- Revenue Code Requirement Table
- OPPS Reduction Factor History

HCPCS*	Description	Status	Fee Screen
A0225	NEONATAL BASE RATE	A	$158.78
A0420	AMBUL WAITG TIME PER HALF HR	M	$33.41
A0425	GROUND MILAGE PER STATUTE MILE	A	$4.25
A0426	AMBUL SVC NON-EMERG ALS 1	A	$208.56
A0427	AMBUL SVC EMERG ALS 1	A	$208.56
A0428	AMBUL SVC NON-EMERG BLS	A	$114.48
A0429	AMBUL SVC EMERG. BLS	A	$114.48
A0430	AMBUL SVC ONE WAY FIXED WING	P	$995.24
A0431	AMBUL SVC ONE WAY ROTARY WING	A	$1,309.63
A0433	ADVANCED LIFE SUPPORT ALS 2	A	$208.56
A0435	FIXED WING MILAGE PER MILE	A	$11.93
A0436	ROTARY WING MILAGE PER MILE	A	$15.57
A0999	UNLISTED AMBULANCE SERVICE	M	$0.01
A0998	AMBUL RESPONSE & TREAT NO TRANSP	A	$114.48

Status Code	Indicates if a code is active (covered) when the database is published and whether additional information is required. A = Active code C = Hysterectomy, sterilization or abortion consent form required D = Deleted code since last published database M = Additional information required to process the claim such as a description of the service rendered or an operative report P = Prior authorization is required


CHAMPS
Community Health Automated Medicaid Processing System

Summer 2009!

Provider Enrollment

- Managing your Provider Information
  - Updating Provider Info
    - Online updating
    - Available at any time
- Domain Access
  - Each Application has a Provider Domain Administrator
  - Can have multiple Provider Domain Administrators
  - Can give system access to other users
  - Can give limited access

Provider Enrollment

- New Enrollments
  - Online Application
  - Available at any time
  - Wait 1-2 weeks for approval
- Updating Provider Information
  - Online updating
  - Can do at any time
  - Required upon license expiration to update provider information

PA & Eligibility

- Prior Authorization
  - Electronic PA Submissions
  - Track PA Status
- Eligibility
  - Direct access through CHAMPS
  - Similar to WebDenis, Netwerkes, EVS

Eligibility

- Maximum batch of 99 beneficiary inquiries
- Maximum date range of a single inquiry will be 90 days
- Eligibility response will contain:
  - The same information as today
  - Scope Coverage codes, program codes, etc will not be returned in response. The Benefit Plan information will be included to replace these codes
- Eligibility can be checked for up to 1 year

Claims

- Claim status
- Direct data entry
- On-line claim adjustments/voids
- Near Real-time Adjudication
- Payment in 1-2 weeks for Electronic Claims

Provider Input Session

Medicaid welcomes suggestions for improvement from the provider community.