MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: All Provider 02-06

Issued: November 1, 2002

Subject: Maternity Outpatient Medical Services (MOMS)
Changes to Eligibility Verification, Claims Submission Procedure and Guarantee of Payment Letter

Effective: December 1, 2002

Programs Affected: MOMS

The MOMS program covers outpatient pregnancy-related services during the prenatal and postpartum period for eligible beneficiaries. All Provider Bulletin 01-03 contains more detailed information regarding the covered services of the MOMS program.

Effective December 1, 2002, all claims for services provided to Maternity Outpatient Medical Services (MOMS) beneficiaries will be processed on the same automated system used for processing Medicaid claims. MOMS paper claims, along with Medicaid paper claims, should be sent to Michigan Department of Community Health, P.O. Box 30043, Lansing, MI 48909. MOMS electronic claims can be submitted with Medicaid electronic claims.

Claim adjudication information for MOMS claims will be included on the weekly Remittance Advice, merged alphabetically with claim information for Medicaid and other DCH-administered programs processed through the automated system. New edit numbers have been established for the MOMS program, which are indicated under the Special Billing Instructions section of this bulletin. Electronic submission of claims is the preferred method for quick and accurate claim reimbursement.

All MOMS covered services are subject to the published policies and procedures applicable under the Medicaid program as they relate to health care and claim submission requirements.

ELIGIBILITY

Effective December 1, 2002, MOMS eligibility information will be available on the Department's Eligibility Verification System (EVS) as well as the Pharmacy Benefit Manager (PBM) on-line claims processing system.

Effective December 1, 2002, the identification card issued to a MOMS beneficiary at the time MOMS eligibility is established will include an eight-digit beneficiary ID number consistent with the beneficiary ID number issued to Medicaid beneficiaries. This ID number is valid throughout the pregnancy and will not change if the beneficiary eligibility subsequently changes from MOMS to Medicaid. This ID number must be used on all claims submitted for MOMS beneficiaries on or after December 1, 2002, regardless of the date the service was provided. MOMS cards issued prior to December 1, 2002 will not be re-issued. Providers must obtain the beneficiary ID number from the Department's EVS for billing purposes.

While some women remain in the MOMS program for their entire pregnancy, many women who initially receive MOMS eligibility are subsequently determined to be eligible for full coverage Medicaid. The beneficiary's ID number issued for MOMS will also be used for Medicaid eligibility. This will not have any impact on how you file your claim. The automated claims processing system will identify the program under which the pregnant woman is covered and will appropriately pay or reject the claim. However, until full coverage Medicaid is determined, MOMS program benefits and prior authorization guidelines will apply. When a MOMS beneficiary becomes eligible for Medicaid, all Medicaid co-payments will be applicable.

GUARANTEE OF PAYMENT LETTER

The Department is committed to making prenatal care available early in the beneficiary's pregnancy. At the time of accepting an application from a pregnant woman, the Local Health Department, Federally Qualified Health Center, and/or Family Independence Agency will conduct an initial eligibility screening to determine if the woman appears to qualify for Medicaid or MOMS. If they determine the woman appears to qualify for either program, they may issue a Guarantee of Payment letter to the pregnant woman to enable her to start care immediately and not have to wait for her identification card. The Department will honor a claim received from a provider rendering outpatient pregnancy-related services in good faith based on this Guarantee of Payment letter. The provider may retain a copy of the Guarantee of Payment letter. The guarantee of payment applies only for providers enrolled in the Michigan Medicaid Program.

The Guarantee of Payment letter, however, may not contain the beneficiary ID number you need to submit a claim. If you provide services to a MOMS beneficiary who has the Guarantee of Payment letter, but has not yet received the yellow MOMS ID card or Medicaid ID card, hold your claim until the beneficiary ID number is available on the EVS and then bill the automated system.

If you are unable to obtain eligibility verification from the Department's EVS within a reasonable period of time, submit your paper invoice, with a copy of the Guarantee of Payment letter, to:

MDCH/Manual Payments Unit
P.O. Box 30688
Lansing, MI 48909

A revised Guarantee of Payment letter (DCH-1164) has been developed and contains the new billing instructions (see attached copy). The current letter (MSA-1132) will not be obsolete and may be used until the current supply is exhausted. However, the new billing instructions in this bulletin should be followed.

PHARMACY SERVICES

Effective December 1, 2002, all pharmacy services provided to MOMS beneficiaries must be billed to the Pharmacy Benefit Manager, First Health Services Corporation. The Medicaid policies and procedures of the recently implemented Michigan Pharmaceutical Best Practices Initiative must be followed beginning December 1, 2002 for any pregnancy-related pharmacy services for MOMS beneficiaries. All payments may be subject to post-payment review.

Pharmacies who provide MOMS services when presented with a Guarantee of Payment letter must bill First Health in one of two ways:

A. Hold the claim until the beneficiary ID number is available on the Department's EVS and then bill First Health via the on-line system.
B. Submit a Universal Claim Form, along with a copy of the Guarantee of Payment letter, to First Health per the instructions in Appendix B of the First Health manual.

During the initial period (up to 30 days), the beneficiary ID number is not on the Department's EVS, the Department will reimburse for medications dispensed. Once the beneficiary's eligibility can be confirmed on the Department's EVS, all claims will be subject to point of sale edits, program limits, Medicaid rates, and Maximum Allowable Cost (MAC) limits, including MAC's on prenatal vitamins. The program presently limits reimbursement for prenatal vitamins to specific maximum allowable costs and, during this time period, providers are encouraged to dispense products within this limit.

Once the beneficiary ID number is on the Department's EVS, compliance with the Michigan Pharmaceutical Best Practices Initiative will be required even if a MOMS beneficiary has previously received a non-preferred medication or is refilling a non-preferred medication. Prior authorization (P.A.) is required for non-preferred drugs and is indicated on the MPPL with a # symbol.

PRIOR AUTHORIZATION

Services that require prior authorization for a Medicaid beneficiary will also require prior authorization for a MOMS beneficiary. To obtain prior authorization for services, providers may write, call or fax:

Department of Community Health
Review and Evaluation Division
PO Box 30170
Lansing, MI 48909

Fax: 1-517-241-0740

For emergencies and inquiries, call: 1-800-622-0276

For pharmacy services, the provider should refer to the Michigan Pharmaceutical Product List to identify products that require prior authorization. Prior authorization is obtained from the Department's Pharmacy Benefit Manager, First Health Services Corporation. To obtain prior authorization for pharmacy services, the provider may write, call, or fax:

First Health Services Corporation
Clinical Call Center
4300 Cox Rd.
Glen Allen, VA 23060

Phone: 1-877-864-9014
Fax: 1-888-603-7696

SPECIAL BILLING INSTRUCTIONS

Providers are reminded to use the EVS to verify the pregnant woman's eligibility for Medicaid or MOMS for the date on which service was provided. If available, you must bill Medicaid. If the EVS system indicates the woman is enrolled in a Medicaid Health Plan (MHP), the claim should be sent to the MHP for reimbursement. If the MHP rejects the claim, the claim, along with the proof of rejection, may be sent to MDCH, Manual Payments Unit (address on page 2 of this Bulletin) to obtain reimbursement.

The following new edits have been established to indicate the claim status for the MOMS Program:

036 Beneficiary is eligible only for MOMS Program on date(s) of service
147 Provider type or diagnosis code is not authorized for treatment under the MOMS program
148 Place of service not acceptable for MOMS Program

MANUAL MAINTENANCE

Retain this bulletin for future reference.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Support, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVED

James K. Haveman, Jr.
Director

Patrick Barrie
Deputy Director
Health Programs Administration

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STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JOHN ENGLER
GOVERNOR

JAMES K. HAVEMAN, JR.
DIRECTOR

GUARANTEE OF PAYMENT FOR PREGNANCY-RELATED SERVICES

NOTICE TO PRENATAL CARE PROVIDERS
PHARMACY, LABORATORY AND DIAGNOSTIC SERVICES AGENCIES

Today's Date	Expected Date of Confinement / **Due Date**
Beneficiary's Name	Beneficiary's Date of Birth
Address (Number and Street) Apt. No.	Medicaid Case Number (if available)
City, State, ZIP code	Medicaid Beneficiary ID Number (if available)

IMPORTANT: All of the above information MUST be completed for the letter to be valid.

This document guarantees that this pregnant woman will be enrolled in the Maternity Outpatient Medical Services (MOMS) Program for a minimum of 45 days from the date listed above. If the beneficiary receives full Medicaid by the end of the 45-day period, the enrollment in the MOMS program will be terminated. If the beneficiary is found not eligible for full Medicaid, coverage through the MOMS program will continue for the entire pregnancy. If available, you must bill Medicaid.

The Department of Community Health **GUARANTEES PAYMENT** through the MOMS Program or the Michigan Medicaid Program for prenatal, delivery (professional fees only) and postpartum care services for the above-named woman for the duration of her pregnancy and two months after the pregnancy ends.

This document should be considered as proof of Medical Insurance Benefits and can be used for billing **pregnancy-related** services only until the beneficiary receives a MOMS card or Medicaid card. Michigan Medicaid-covered maternity services and fee screens apply.

Pregnancy-related covered services include:

1. Prenatal care
2. Pharmaceuticals and prescription vitamins
3. Laboratory
4. Labor and Delivery (Professional Fee only)
5. Postpartum care through two calendar months after pregnancy ends
6. Radiology and Ultrasound
7. Family planning/contraceptive services, including professional fee for postpartum sterilization
8. Maternal Support Services (MSS)
9. Outpatient hospital care (excluding outpatient delivery services)
10. Childbirth education
11. Other pregnancy-related care with prior authorization

If you have questions regarding billing or you are providing a medical service that is not listed above, please refer to the back of this letter for instructions on billing and prior authorization procedures.

If you require this document for your files, please make a copy and return the original to the beneficiary.
Guarantee of payment applies only for providers enrolled in the Michigan Medicaid Program.

Name of Contact Person	Signature		Date
Phone Number ( )			
Name of Issuing Agency			
Agency's Mailing Address (Number and Street) (Suite)	City	**MI**	ZIP Code

DISTRIBUTION:
WHITE: Beneficiary
YELLOW: Send to: **MDCH – MOMS**
PO Box 30479
Lansing, MI 48909-7979
PINK: Issuing Agency File Copy

Patrick Barrie, Deputy Director
Health Programs Administration

DCH-1164 (10-02) (W) Revises MSA-1132 which may be used

PROVIDER BILLING INSTRUCTIONS

ELIGIBILITY:

MOMS' eligibility may be obtained through the Department of Community Health's Eligibility Verification System (EVS). The Department will issue a beneficiary ID number to be used when billing for services. If the beneficiary receives full Medicaid and enrolls in a Medicaid Health Plan, the health plan's policies and procedures will apply. If you are not a participating provider with the health plan, the beneficiary should be referred to the health plan before services are rendered.

BILLING INSTRUCTIONS:

- Electronic submission of claims is the preferred method for quick and accurate claim reimbursement.
- All services must be billed within one year of the date of service. Pharmacy services should be billed within six months of the date of service.
- Claims must be completed following standard Medicaid billing and reimbursement guidelines contained in the Medicaid Provider manuals. Claims must be submitted to the same location where you submit your Medicaid claims.
- Private insurance must be billed first, if applicable.
- It is recommended you hold the claim for services provided prior to the beneficiary receiving her MOMS and/or Medicaid card until the beneficiary ID number is available on the EVS and then bill using the automated process.
- If you are unable to obtain the beneficiary ID number from the EVS within a reasonable period of time, or if you have provided services to a beneficiary and were unaware of her enrollment in a Medicaid Health Plan, submit your paper invoice and put the number beginning with 'M-' that appears in the upper right corner of the Guarantee of Payment letter in the area reserved for the beneficiary ID number.
- Submit your paper invoice with a copy of the Guarantee of Payment letter to:

  MDCH/MANUAL PAYMENTS UNIT
  P.O. BOX 30688
  LANSING, MI 48909

- MOMS claim adjudication information will be included in the weekly Remittance Advice, merged alphabetically with Medicaid and other MDCH-administered programs. If your claim does not appear within a reasonable amount of time, you may contact the Medicaid Provider Inquiry Line at **1-800-292-2550**.
- All MOMS covered services are subject to the published policies and procedures applicable under the Medicaid program as they relate to health care and claim submission requirements.

PRIOR AUTHORIZATION:

If your service does not meet the definition of pregnancy-related services listed on the front of this letter or if the service normally requires prior authorization by the Medicaid program, please submit your request, by mail, to Michigan Department of Community Health, Review and Evaluation Division, P.O. Box 30170, Lansing, MI 48909 or you may fax it to 1-517-241-0740.

PHARMACY SERVICES:

Pharmacy services provided to MOMS beneficiaries must be billed to the Pharmacy Benefit Manager, First Health Services Corporation. Refer to the Michigan Pharmaceutical Product List to identify products that may require prior authorization. To obtain prior authorization, you may write to: First Health Services Corporation, Clinical Call Center, 4300 Cox Rd., Glen Allen, VA 23060, phone: 1-877-864-9014, or fax: 1-888-603-7696. For eligibility concerns and/or general questions, contact the Technical Call Center at 1-877-624-5204.

Pharmacies who provide MOMS services, when presented with this Guarantee of Payment letter, have the option of billing First Health in one of two ways:

A. Hold the claim until the beneficiary ID number is available on the Department's EVS and then bill First Health via the on-line system.
B. Submit a Universal Claim Form, along with a copy of this Guarantee of Payment letter, to First Health per the instructions in Appendix B of their manual.

AUTHORITY:	Title XIX of the Social Security Act	The Department of Community Health is an equal opportunity employer, services and programs provider.
COMPLETION:	Is Voluntary, but is required if Medical Assistance program payment is desired.	