MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: All Provider 04-05

Issued: June 1, 2004

Subject: New Editing;
Explanation Code Crosswalk; and
Crossover Claims

Effective: Upon Receipt

Programs Affected: Medicaid, Children's Special Health Care Services

This bulletin provides information regarding changes being implemented as part of the Michigan Department of Community Health's continuing implementation of HIPAA-related transactions.

NEW EDITING

Institutional Claims

Institutional claims will reject when value codes are reported incorrectly. A specific value code can be used only once on a claim--it cannot be repeated. The Remittance Advice (RA) will report:

- 630 (payment adjusted because coverage/program guidelines were not met or were exceeded), or
- Adjustment Reason Code B5 (payment adjusted because coverage/program guidelines were not met or were exceeded), and
- Remark Code M49 (missing/incomplete/invalid value code(s) or amount(s))

Professional and Dental Claims

Providers submitting ASC X12N 837 claims to MDCH, that were previously adjudicated by another payer, may have the claims rejected due to the adjustment reason codes supplied from the prior payer. The MDCH RA will report:

- 958 (Medicaid cannot pay your claim based on the claim adjustment reason codes supplied from the prior payer), or
- Adjustment Reason Code B5 (payment adjusted because coverage/program guidelines were not met or were exceeded), and
- Remark Code N36 (claim must meet primary payer's processing requirements before we can consider payment)

MDCH cannot adjudicate a claim until the prior payer's processing requirements have been met. Refer to the Coordination of Benefits chapter of the Medicaid Provider Manual for more information on Medicaid liability when other payers are involved.

The definition of edit 987 has been revised. This edit may appear when a claim has been adjudicated by another payer before being submitted to MDCH.

- 987 (the claim adjustment reason codes supplied by the prior payer have been used to calculate the amount payable by Medicaid), or
- Adjustment Reason Code 42 (charges exceed our fee schedule or maximum allowable amount), and
- Remark Code N14 (payment based on contractual amount or agreement, fee schedule, or maximum allowable amount)

EXPLANATION CODE CROSSWALK

The MDCH has created a crosswalk to assist providers in the transition to the HIPAA compliant adjustment reason codes, group codes, and remark codes that will replace the current MDCH proprietary edit/explanation codes in the paper and electronic remittance advices. The crosswalk is available, and will be maintained, on the MDCH website at www.michigan.gov/mdch , click on Providers, HIPAA, HIPAA Implementation Materials, Companion Guides/Data Clarification Documents. Updates will be made to the crosswalk as needed to incorporate future edit/code changes.

CROSSOVER CLAIMS (COORDINATION OF BENEFITS)

In early summer, the MDCH will begin accepting crossover claims. Initially, crossovers will be limited to Medicare Part B claims processed by Wisconsin Physician Services (WPS), the Medicare Part B carrier for Michigan, for the selected provider types submitting claims on the ASC X12N 837P version 4010A1. The initial group will include:

Ambulance	Chiropractors	Independent Laboratories
Physicians	Podiatrists	Optometrists
Medical Clinics	Oral Surgeons	

Claims submitted by Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Certified Nurse Practitioners, and Physical Therapists in private practice directly enrolled with MDCH will also be part of the initial group.

The crossover process allows providers to submit a single claim for individuals dually eligible for Medicare and Medicaid, or qualified Medicare beneficiaries eligible for Medicaid payment of co-insurance and deductible to the Medicare carrier (WPS), and have it also processed for Medicaid reimbursement. A remittance advice (RA) will be generated from WPS with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark does not appear on the WPS RA, a separate claim will have to be submitted to the MDCH.

The following types of claims will be excluded from the crossover process between WPS and MDCH:

- Totally denied claims
- Claims denied as duplicates or for missing information
- Adjust claims (replacement or void/cancel claims)
- Claims reimbursed at 100 percent from WPS
- Claims for dates of service outside Medicaid's effective and end dates
- Part B claims from any Medicare carrier other than WPS

Providers must resolve denied claims with WPS unless the service is an excluded benefit for Medicare, but covered by Medicaid (e.g., insertion of an IUD). In those cases, the excluded Medicare service can be billed directly to Medicaid. Providers must continue to submit Part B claims from any Medicare carrier other than WPS, and any claims Medicare has adjusted, directly to MDCH.

SPECIAL INSTRUCTIONS FOR CROSSOVER CLAIMS

Providers must include their Medicaid provider ID number, along with their Medicare provider ID number, on the claim sent to Medicare. The Medicaid ID must be reported by repeating Loop ID 2010AA REF01 and REF02 in the 837P version 4010A1. The information must be entered as follows:

- Loop ID 2010AA REF01: enter "1D" for Medicaid
- Loop ID 2010AA REF02: enter the 9-digit Medicaid provider ID number (2-digit provider type followed by the 7-digit number)

This information will be passed to the MDCH by WPS, and will be the basis for identifying the provider for purposes of claims processing. If the Medicaid information is not included in the claim sent to Medicare, Michigan Medicaid will not be able to process the claim.

Once payment is received from Medicare and the MA07 remark code appears on the Medicare RA, providers should expect to see the claim appearing on the Medicaid RA within 30 days. If the claim does not appear within that time, a claim should be submitted directly to MDCH showing all the Medicare payment information.

Expansion of Crossover Claims

As the MDCH expands its processing of crossover claims to include additional provider types, notice will be sent to the affected providers.

QUESTIONS

Any additional questions regarding this bulletin should be directed to Provider Support, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may telephone toll-free 1-800-292-2550.

APPROVAL

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