

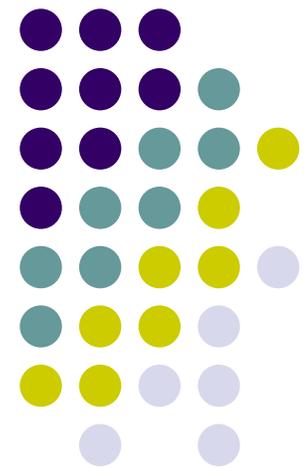
CHAMPS

Michigan Medicaid

Institutional Claims

HIPAA 5010

Jan. 1, 2012



*Michigan Department
of Community Health*



Rick Snyder, Governor
Olga Dazzo, Director

Why HIPAA 5010



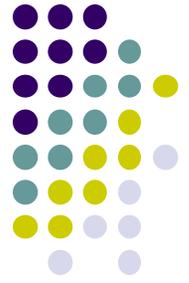
- Federally required for claims submission effective January 1, 2012
- Supports National Provider Identifier (NPI)
- Supports ICD-10 codes, effective October 1, 2013
- Allows for use of ICD-9 or ICD-10 codes by DOS
- Expands the number of reportable occurrence and occurrence span codes and dates from 4 to 12

General 5010 Changes



- Larger name fields
- Prohibits use of P.O. Box for billing provider address
- Diagnosis field size expanded in preparation for using ICD-10 codes in October 2013.
- Billing provider requires 9 digit zip code
- Changes made to the AMT segments for COB claims (approved and allowed deleted)

CHAMPS Templates



- New templates are required January 1, 2012.
- Templates previously saved will not be available for use.
- There is no change to the number of templates you can create- five are allowed.

Set up your new templates as soon as possible when new screens go live January 2012!

Claim Adjustments



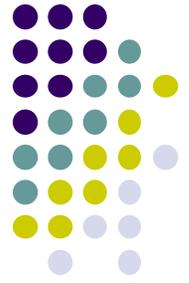
- When adjusting an original 4010 claim, adjustor will be prompted to remove 4010 information that is no longer required
 - If NDC Unit Price was blank on a 4010 claim the field will be disabled. If field has a value, you must remove the amount prior to submission.
- When adjusting an original 4010 claim, adjustor will be prompted to add required 5010 information.
 - covered, non-covered, co-ins or lifetime reserve days will have to be zeroed out and value codes will have to be added
 - if POA indicator is invalid provider will be prompted to change to valid indicator
- Non-covered line charges added (already on claim submission screen)

Direct Data Entry (DDE) Changes



- For multiple NDC's additional service line(s) may be added
- When displaying a 4010 claim, the second PA number will be moved to PRO field
- E-Code increased from 3 to 12 reportable occurrences
- Occurrence Span Code and dates increased from 4 to 12 reportable occurrences

DDE Changes



- LTC Covered, Non-Covered, Co-Ins and Lifetime Reserve Days are eliminated and Value codes (80 – 83) must be reported
- Prior Authorization (PA) number field should contain the MDCH issued PA
- PRO field should contain the MPRO Pacer number
- For Inquiry screen, the header PA, PRO and Referral numbers get copied to the line

DDE Changes



- Attending Provider is now required
- The PRO number at the header is automatically copied to the service line level
- The second PA number field was replaced by the referral number field
- All secondary surgical procedures now require the date

DDE Service Line Summary Grid



- Added
 - Non Covered Charges
 - Now viewable after adding service line item

DDE - Fields Removed



Header

- Pay-To Provider
- Subscriber Gender
- Subscriber Date of Birth

Service Line

- Second and third occurrence of NDC
- NDC Unit Price
- Second occurrence of Prior Authorization Number
- Rate

DDE - New Fields



Header

- Rendering Physician
- Referring Physician
- Referral Number
- PRO Number
- Auto Accident
State/Providence
- Delay Reason Code
- Remittance Date
- Other Operating Provider

Line

- Operating Physician
- Other Operating
Physician
- Rendering Physician
- Referring Physician
- Procedure Description
- Prescription Link
- NDC Prescription Date
- NDC Qualifier

Delay Reason Code



- Provides MDCH with the reason that the claim submission to MDCH was delayed
- Helps prevent claim denials for “timeliness”
- Always use Delay Reason Codes if applicable
- If related to third party liability (TPL), always include the TPL remit date on the claim

Changed – Attending Provider Information is now required

New – Auto Accident State /Province

Close Submit Claim Save as Template Reset

Institutional Claim:
Note: Asterisks (*) denote required fields. [Billing Instructions](#)

Basic Claim Info
Provider | Beneficiary | Claim | Service Line

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

ATTENDING PROVIDER INFORMATION
Provider ID: * Type: * Taxonomy Code:

BENEFICIARY INFORMATION

BENEFICIARY
Beneficiary ID: *
Last Name: * First Name: * MI: Suffix:
Date of Birth: * Gender: *

CLAIM INFORMATION

CLAIM DATA
Patient Control No.: *
Medical Record No.:
Type of Bill: * (Enter 4 digits with leading zero.)
Statement Dates: From: * To: *
Admission Date/Hour: - :
Admission Type:
Admission Source: *
Discharge Hour: :
Patient Status: *
Principal Diagnosis Code: * POA: * Auto Accident State/Province:

Added - Delay Reason Code
Remittance Date
PRO Number
Referral Number

Changed – Occurrence/
and Occurrence Span Information can
now have 12 max

Close Submit Claim Save as Template Reset

CONDITION INFORMATION

1. Condition Code: * Add Another

OCCURRENCE INFORMATION

1. Occurrence Code: * Occurrence Date: mm dd yyyy * Add Another

OCCURRENCE SPAN INFORMATION

1. Occurrence Span Code: *

From Date: mm dd yyyy * Through Date: mm dd yyyy * Add Another

VALUE INFORMATION

1. Value Code: * Value Amount: \$ * Add Another

DELAY REASON

Delay Reason Code: 10-Administration Delay in the Prior A

OTHER INSURANCE

Other Subscriber: 10-Administration Delay in the Prior A

Payer Responsibility: 11-Other

Payer ID Number: 15-Natural Disaster

Subscriber Last Name: 2-Litigation

Insured's Group Number: 3-Authorization Delays

Claim Filing Indicator: 4-Delay in Certifying Provider

1. Reason Code: Amount: \$ Adjustment Quantity:

2. Reason Code: Amount: \$ Adjustment Quantity: Add Another Reason Code

Add Another Payer

PRIOR AUTHORIZATION/PRO/REFERRAL NUMBER

Prior Authorization Number: MDCH PA: Yes No PRO Number:

Referral Number:

Remittance Date: mm dd yyyy

Subscriber Member ID:

First Name: MI: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: \$ *



Menu

Close Submit Claim Save as Template Reset

Top

CONDITION INFORMATION

OCCURRENCE INFORMATION

OCCURRENCE SPAN INFORMATION

1. Occurrence Span Code: *

From Date: mm dd yyyy *

Through Date: mm dd yyyy *

Add Another



2. Occurrence Span Code:

From Date: mm dd yyyy

Through Date: mm dd yyyy

Delete Row

3. Occurrence Span Code:

From Date: mm dd yyyy

Through Date: mm dd yyyy

Delete Row

4. Occurrence Span Code:

From Date: mm dd yyyy

Through Date: mm dd yyyy

Delete Row

5. Occurrence Span Code:

From Date: mm dd yyyy

Through Date: mm dd yyyy

Delete Row



VALUE INFORMATION

DELAY REASON

Delay Reason Code: *

OTHER INSURANCE INFORMATION

Added – Other Operating Physician Information

Rendering Physician Information

Referring Physician Information

Close Submit Claim Save as Template Reset

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

Diagnosis Version:

Admitting Diagnosis Code: PPS/DRG:

Reason For Visit: 1: 2: 3:

E-Code: POA: Add Another

Other Diagnosis Information

1. Other Diagnosis Code: * POA: Add Another

PROCEDURE INFORMATION

Principal Procedure Code: * Procedure Date: *

Other Procedure Information

1. Other Procedure Code: * Procedure Date: Add Another

OPERATING PHYSICIAN INFORMATION

Provider ID: * Type:

OTHER OPERATING PHYSICIAN INFORMATION

Provider ID: * Type:

RENDERING PHYSICIAN INFORMATION

Provider ID: * Type:

REFERRING PHYSICIAN INFORMATION

Provider ID: * Type:

Claim Note:

Characters Remaining:

Yes No

Added – HCPCS Description
Non-covered Line Charges

Operating Physician and Other Operating Physician ID

Rendering Physician ID

Referring Physician ID

Qualifier and Prescription/Link No.

Changed – Line Item Grid



Does this claim have backup documentation? Yes No

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code: Modifiers: 1: 2: 3: 4:

Service Date: mm dd yyyy HCPCS Description: Characters Remaining: 80

Last Date of Service: mm dd yyyy

Service Units: *

Total Line Charges: \$ * Non-covered Line Charges: \$

Operating Physician ID: (If different from header) Type:

Other Operating Physician ID: (If different from header) Type:

Rendering Physician ID: (If different from header) Type:

Referring Physician ID: (If different from header) Type:

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Add Service Line Item Item

VY-Link Sequence Numbr
XZ-Pharmacy Prescriptio

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges
			1	2	3	4	Service Date	Last DOS			

Questions

