STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

March 2009

Dear Prepaid Inpatient Health Plan and Community Mental Health Services Program Providers (CMHSP):

In compliance with auditing and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and to assure that claims for Children's Home and Community Based Services Waiver Program (CWP) services are correctly paid, modified electronic claims submission rules have been implemented for the CWP, effective with Pay Cycle 6. An internal test was completed using in-house data, and we believe these procedures resolve problems experienced by CMHSPs over the past year. Until the new Community Health Automated Medicaid Processing System (CHAMPS) is operational, the procedures outlined in this letter must be used to enable payment to be made for CWP services. This letter provides:

- Direction regarding use by CMHSPs of a State-defined modifier to assure payment is made to the appropriate billing CMHSP;
- Clarification regarding use and association of **billing** National Provider Identifier (NPI) numbers and **rendering** NPI numbers in CHAMPS; and
- Guidance regarding submitting claims for services with dates of service greater than 12 months.

Use of a State-defined Modifier

The NPI crosswalk has been programmed to recognize a State-defined modifier (UC) to assure payment will be made to the billing CMHSP, not to the rendering provider. This modifier identifies the billing CMHSP's NPI number as a CMHSP billing (legacy system) provider type 77. In essence, this modifier indicates the CMHSP is billing Medicaid fee-for-service for a CWP beneficiary. To assure correct payment, the UC modifier must be reported on the first claim line, in the first position following the procedure code. Note: If the first claim line is a service for which there is a modifier that affects payment (i.e., TE, TD or TT), the UC modifier must be in the first position. The TE, TD or TT modifier, if appropriate for the code, must still be reported following modifier UC.

Use of Billing and Rendering NPI Numbers

Per HIPAA requirements, and as detailed in the Medicaid Provider Manual, in all instances when the rendering provider has or is expected to have an NPI number, that number must be entered on each claim service line in Loop 2310B. Rendering Provider indicates the hands-on provider. If the hands-on provider is a health care provider expected to have an NPI (e.g., psychologist, social worker, nurse, psychiatrist, physical therapist), that provider's NPI must be entered on the service claim line. If the hands-on provider is a provider who is not expected to have an NPI (e.g., provider of CLS or aide-level respite), no rendering NPI number should be entered on the service claim line.

The NPI number of the billing CMHSP must be entered in Loop 2010AA. If the CMHSP has more than one NPI number, the number associated with the CMHSP as a provider type 77 (in the legacy system) should be used.

Association of Billing and Rendering NPI Numbers

In those instances when the rendering provider is also an enrolled Medicaid provider (e.g., psychiatrist, nurse), the CMHSP must associate the NPI of the rendering provider with the CMHSP's billing NPI number in the CHAMPS online enrollment. (Note: if the CMHSP has more than one NPI, the association must be with the NPI number the CMHSP will use on claims for CWP services, i.e., use the number associated with the CMHSP as a provider type 77 in the legacy system.)

In all instances when the rendering provider has an NPI number but Medicaid does not enroll the provider (e.g., social worker, psychologist), the CMHSP cannot associate the rendering provider's NPI with the CMHSP's billing NPI number. (You will be notified if this situation should change and require you to associate these providers.)

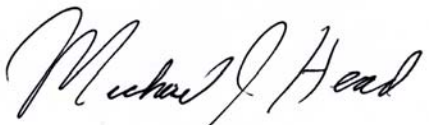
Submitting Claims for Services with Dates of Service Greater than 12 Months

The Remittance Advice (RA) for claims with dates of service greater than 12 months will return the 158 edit and will identify the status of the claim (e.g., "pend", reject", etc.). Any claim with dates of service prior to January 1, 2006, will pend on the 503 edit and will need to be manually processed. To expedite payment for other services, do not put any service line that you expect to pend on a claim with other services.

Please direct questions regarding billing or this letter to Provider Support at: 1-800-292-2550 or by e-mail to ProviderSupport@michigan.gov.

Sincerely,

Stephen Fitton, Acting Director
Medical Services Administration



Michael J. Head, Director
Mental Health and Substance Abuse Administration