Michigan Medicaid

Professional Session

Marquette, MI

June 5th, 2013 9am-11:30am

Agenda

- Policy Updates
- CHAMPS Updates
- Common Denials
- Claim Stats
- Claim Limit List
- Spendown
- ICD-10

Policy Updates

Policy

- Primary Care Rate Increase
  - MSA 12-66
    - Physicians with specialty designations of family medicine, general internal medicine, and pediatric medicine qualify as primary care providers for purposes of increased payment.
    - CMS has identified that E/M codes 99201 through 99499 are subject to the rate increase. In addition, vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474 are also eligible for the higher payment.
    - For dates of service on and after January 1, 2013 and through December 31, 2014.

Policy

- Claim Predictive Modeling
  - MSA 12-65
    - Beginning January 1, 2013, the Michigan Department of Community Health (MDCH) will implement a new predictive modeling process for all fee-for-service claims submitted though the Community Health Automated Medicaid Processing System (CHAMPS). The predictive modeling process will be part of CHAMPS and will use advanced screening technology to identify billing irregularities.
    - Any claim that has been flagged for review will suspend with the following Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC). The CARC and RARC information will be available in CHAMPS.
      - CARC: 133 – The disposition of the claim/service is pending further review. Use Group Code OA.
      - RARC: N10 – Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

Policy

- Medicaid Enrollment of Physician Assistants and Nurse Practitioners
  - MSA 12-42
    - This bulletin provides information describing the mandatory enrollment of licensed Physician Assistants (PAs) and Nurse Practitioners (NPs) who render, order, or bill for covered services to Medicaid beneficiaries.
    - As of January 1, 2013, PAs and NPs will no longer bill for rendered services under their delegating/supervising physician's National Provider Identifier (NPI) and must be uniquely identified on all claims.
    - The NPI of the NP's or PA's delegating/supervising physician will also be required on claim submissions for reimbursement.

CHAMPS Updates

CHAMPS Updates

- Claims denying for Other Insurance – Medicare – Beneficiary is Medicare Eligible but not enrolled – hitting even though service is non covered by Medicare – scheduled 6/28/2013
- CCI editing is setting across claim types in error. Professional claims should not hit CCI editing against Institutional claims – scheduled 9/27/2013
- CARC 122 being processed as an adjustment in error. There should be Medicaid Liability for CARC 122 - future

Common Denials

Common Denials

- Reason Code – 8 Remark Code - N65
  - 8 The procedure code is inconsistent with the provider type/specialty (taxonomy)
  - N65 Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider
- Provider does not have the correct specialty on file to perform the service rendered

Common Denials

- Reason Code -185 Remark Code – N198
  - 185 The rendering provider is not eligible to perform the service billed
  - N198 Rendering provider must be affiliated with the pay-to provider
- The NPI listed as the rendering provider on the claim is a type 2 NPI, not a type 1

Common Denials

- Reason Code – 96 Remark Code – N65
  - 96 Non-covered charge(s)
  - N65 Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provide
- The services rendered are not covered by Michigan Medicaid

Common Denials

- Reason Code – 97 Remark Code – M80
  - 97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
  - M80 Not covered when performed during the same session/date as a previously processed service for the patient
- Procedure combination is not covered un NCCI – modifier may be required

Common Denials

- Reason Code – 16 Remark Code – M119
  - 16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
  - M119 Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC)
- Procedure code submitted requires a valid NDC

Common Denials

- Reason Code – 18 Remark Code – M86
  - 18 Exact duplicate claim/service
  - M86 Service denied because payment already made for same/similar procedure within set time frame
- Duplicate – check claim limit list for payment information

Common Denials

- Reason Code – 22 Remark Code – N36
  - 22 This care may be covered by another payer per coordination of benefits
  - N36 Claim must meet primary payer's processing requirements before we can consider payment
- Adjustment reason code is being reviewed

Common Denials

- Reason Code – 6 Remark Code – N129
  - 6 The procedure/revenue code is inconsistent with the patient's age
  - N129 Not eligible due to the patient's age
- Procedure code not valid for patient's age, check for age appropriate code

Common Denials

- Reason Code – 24 Remark Code – N130
  - 24 Charges are covered under a capitation agreement/managed care plan
  - N130 Consult plan benefit documents/guidelines for information about restrictions for this service
- Check beneficiary's eligibility and submit claim to the appropriate Managed Care plan

Common Denials

- Reason Code – 11 Remark Code – N10
  - 11 The diagnosis is inconsistent with the procedure
  - N10 Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor
- The procedure code and diagnosis code combination being billed is not payable by Michigan Medicaid, review for more specific diagnosis code

Common Denials

- Reason Code – 31 Remark Code – N65
  - 31 Patient cannot be identified as our insured
  - N65 Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provide
- Beneficiary does not have coverage for the service being rendered

Common Denials

- Reason Code – 31 Remark Code – N365
  - 31 Patient cannot be identified as our insured
  - N365 This procedure code is not payable
- Beneficiary does not have coverage for the date of service

Common Denials

- Reason Code – B5 Remark Code – N10
  - B5 Coverage/program guidelines were not met or were exceeded
  - N10 Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor
- Limits/Frequency – check claim limit list for previously paid claims

Claim Stats

Claim Stats

FFS Claims Pay Cycle Summary	
Data as of: 05/28/2013 02:05 AM	
Payment Cycle Number	21
Payment Cycle Date	05/15/2013
Amount Paid By State ($)	46,833,852
Total Provider Set RA Generation	10,249
Total Tax Id Processed	7,799
Total RA Sent for Printing	10,249
Total Claims Processed	399,602
Total Encounters Processed	606,299
Total Claims & Encounters Processed	1,005,901
Receivable Amount ($)	3,841,632
Payable Amount ($)	49,231,283

Claim Limit List

Finding Duplicates in CHAMPS

- Claim Limit List
  - To use when claims get duplicate or limit rejections.
  - Ex: CARC 18, B5, B13

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- Pull up the TCN and click on the blue hyper linked TCN to bring up the claim header.

HTTPS://SSO.MDCH.STATE.MI.US/DCH-CHPPRD/ECAMS/CNSICONTROLSERVLET - MICROSOFT INTERNET EXPLORER

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- Click on the show menu from the header screen and select SERVICE LINE LIST. You can also click on the red and green file folder icon on the right side of the page to go into the service lines list.

WELCOME TO MMIS - MICROSOFT INTERNET EXPLORER

•Click on the service line that is getting the duplicate rejection. In this example there is only 1 line on the claim.

SERVICE LINE LIST - MICROSOFT INTERNET EXPLORER

Header TCN: 3111 [redacted] 000
Beneficiary ID: 00 [redacted]
Name: [redacted]
Show: ---SELECT---

Service Lines:
Filter By : And Go

TCN	Revenue Code	Procedure Code	From Date	To Date	Units	Submitted Charges	Approved Amount	Claim Status
311[redacted]001		D0140	03/07/2011	03/07/2011	1	$50.00	$0.00	Denied

<< Prev View Page 1 Next >> 1 Go Page Count SaveToXLS

Cancel

Page ID: dlgViewServiceLineList(Claims)

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•Go to the top right of the service line detail page and in the SHOW BOX - Select - Claim Limit List. This is only available on the LINE of a claim. This option is NOT available on the HEADER show menu.

Show: ---SELECT---
---SELECT---
Claim Cutbacks
Claim Enhancement Amounts
Claim Header Detail
Claim Limit List
Claim Notes
Indicators
Other Payers Information
Service Line List
Situational Information

Service Line Detail:

TCN: 3111 [redacted] 001
Adjustment Source:
Claim Type: K - Dental
Claim Status: Denied
Pricing Rule: Default R

Benificiary ID: 0 [redacted]
Gender: Female
Benefit Plan: Full Fee-for-service Medical Assistance
Last Name: [redacted]
DOB: [redacted]
First Name: [redacted]
Age: 28

Rendering Provider ID: * Type: * Taxonomy: Referring Provider ID: Type:
Auth #: Auth #: Place of Service: 11-Office

Procedure Code: D0140 * Oral Cavity: Placement Date: 03/07/2011 *
Tooth # : Surface Code : 1: 2: 3: 4: 5:
Manual Units: Billed Units: 1 * Paid Units: 1
Manual Price:

Submitted Charges: $50.00 * Billed Amount: $50.00 Approved Amount: $0.00
Medicare Paid: Medicare Co-insurance: Medicare Deductible:
Other Insurance: Other Insurance Co-Pay: Other Insurance Deductible:

•You will be able to view the Current Claim and the History Claims information. On this screen you can see what the current claim is hitting against that is causing the duplicate or limit rejection. You can also see the PAID date where MDCH shows that the claim was previously paid.

Show: ---SELECT---

Current Claim:

TCN	From Date	To Date	Facility Type	Billing Provider NPI	Servicing Provider NPI	Procedure Code	Revenue Code	Modifiers	Billed Amount	Paid Amount	Paid Date	Units	Error Code
31110 [redacted] 1	03/07/2011	03/07/2011	11-Office	15 [redacted]	[redacted]	D0140			$50.00	$0.00	03/17/2011	1	1227

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History Claims:

TCN	From Date	To Date	Facility Type	Billing Provider NPI	Servicing Provider NPI	Procedure Code	Revenue Code	Modifiers	Billed Amount	Paid Amount	Paid Date	Units
3111 [redacted] 1001	03/07/2011	03/07/2011	11-Office	[redacted]	1 [redacted]	D0140			$50.00	$11.89	03/24/2011	1

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SPEND DOWN

Spend-down coverage and how it works
Finding the DCH policy
Caseworker responsibility
Beneficiary responsibility
Provider responsibility
Aka Medicaid Deductible

Medicaid Deductible

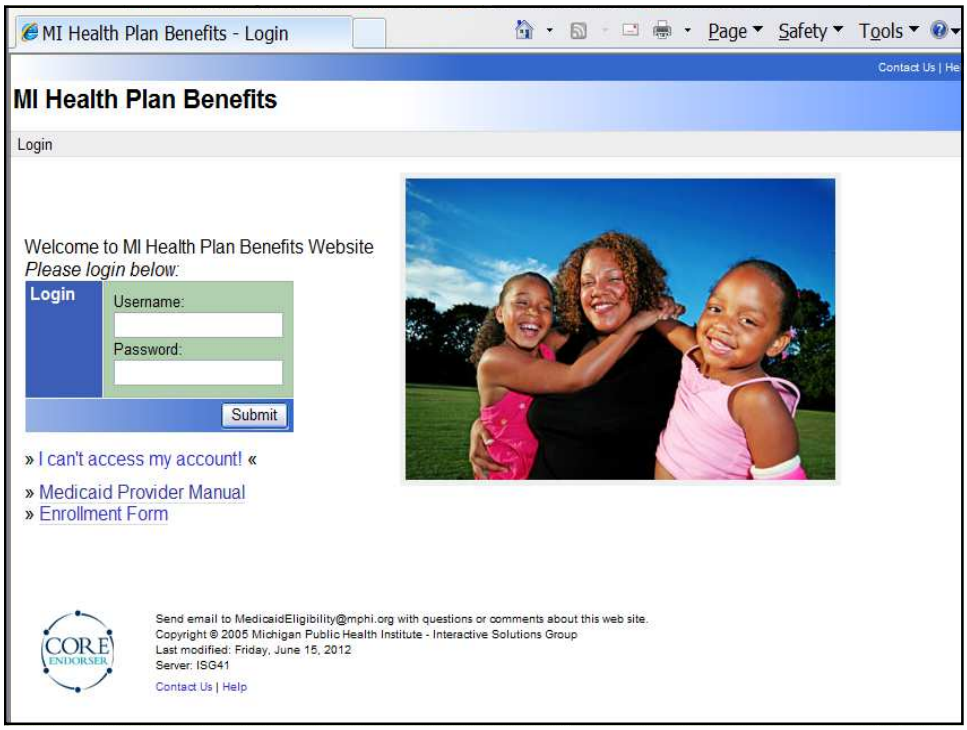
- Provider Manual in the Chapter **Beneficiary Eligibility**
- **Section 4-Medicaid Deductible Beneficiaries** (Spend-down)
- Medicaid deductible means that the beneficiary must incur ***medical expenses*** each month equal to, or in excess of, an amount determined by the local DHS worker to qualify for Medicaid.
- **Process:**
  - Beneficiary presents proof of ANY medical expense incurred to the DHS worker. Items they can use e.g., care from hospitals, doctors, clinics, dentists, drugs, medical supplies and equipment, health insurance premiums, transportation to get medical care, personal assistance services, adult home help services, and other services from Community Mental Health.

Medicaid Deductible

- Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. In other words provider would not have to verify concrete amounts via EOB-this will speed up the process to get that eligibility started for the beneficiary.
- **Beneficiary should be advised to contact their respective DHS caseworkers within 10 days of receipt of any charges they may use to satisfy their deductible**
- **Spend down is also called Medicaid Deductible**

Great NEWS!

- Providers now have access to a website that will display the Spend-down amount in their eligibility response on their 'MI Health Plan Benefits' page
  - and 270/271 transaction.
- https://healthplanbenefits.mihealth.org



Logout | Home | Multiple Eligibility | User Admin | Applications | Print |

MI Health Plan Benefits

Home > Individual Eligibility

Eligibility
Eligibility Service: Medicaid

Beneficiary ID
Medicaid ID:

Name
Last: First:
Middle:

Social Security Number
SSN:

Date of Birth (MM/DD/YYYY)
DOB:

Coverage Period * (MM/DD/YYYY)
Start Date: 09/01/2011 End Date: 09/30/2011

Submit Default

mihealth card

Residence County	63 OAKLAND
FIA Office	
Case Number	
Worker Load	

Member/ Patient Name	Gender	Date of Birth	Coverage Period
	Male		09/01/2011 To 09/30/2011

Status	Benefit Plan	Comments	Dates
Co-Pay	SPENDOWN	**Patient Pay:** $1400.00	09/01/2011 To 09/30/2011

Spend-down amount per DHS for current month only.

Michigan Department of Community Health
MDCH

ICD-10 Implementation

Get Ready!

HIPAA Implementation ICD-10

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ICD-10 Implementation Overview

- Definition of ICD-10
- Regulatory Requirements
- Benefits of ICD-10 Implementation
- Provider Impact

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What is ICD-10?

- 10th revision of standard medical code sets used for:
  - ✓ Diagnosis codes used by all providers in health care settings (ICD-10-CM)
  - ✓ Procedure codes used for hospital claims and inpatient hospital procedures (ICD-10-PCS)
- Classification of medical code sets
- Does not affect use of CPT or HCPCS
- Required by HIPAA

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Regulatory Requirements (PENDING CMS Ruling)

- HHS published final regulations (45CFR 162.1002) on January 16, 2009
- **MDCH recognizes the compliance date of *October 1, 2014, thus all MDCH planning efforts will adjust according to this new timeline.***
- **All** HIPAA covered entities must use ICD-10
- Services rendered on and after ***October 1, 2014*** must use ICD-10-CM and ICD-10-PCS
- ICD-9 codes, based on date of service, will continue to be sent and received for some time

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Why ICD-10?

- ICD-9 codes don't provide the needed detail
- ICD-9 has obsolete groupings of disease families
- Provides additional detail for better analysis
- Modernized terminology for:
  - ✓ New conditions
  - ✓ New treatments
  - ✓ New technology
- Better information for public health, quality measures and bio-surveillance

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What Changes with ICD-10?

- More extensive than a yearly code update
- Requires changes to most clinical and administrative systems and processes
- Could result in changes to reimbursement and coverage

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Let's Look at an Example

ICD-9 Code- E917.0 - Striking against or struck accidentally in sports without subsequent fall

ICD-10-CM- Sports injuries now include sport and reason for injury

So what does this mean?

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Now 28 possible ICD-10-CM W21 codes for E917.0

W21.00	Struck by hit or thrown ball, unspecified type	W21.4	Striking against diving board
W21.01	Struck by football	W21.11	Struck by baseball bat
W21.02	Struck by soccer ball	W21.12	Struck by tennis racquet
W21.03	Struck by baseball	W21.13	Struck by golf club
W21.04	Struck by golf ball	W21.19	Struck by other bat, racquet or club
W21.05	Struck by basketball	W21.210	Struck by ice hockey stick
W21.06	Struck by volleyball	W21.211	Struck by field hockey stick
W21.07	Struck by softball	W21.220	Struck by ice hockey puck
W21.09	Struck by other hit or thrown ball	W21.221	Struck by field hockey puck
W21.31	Struck by /stepped on by shoe cleats	W21.81	Striking against or struck by football helmet
W21.32	Struck by /skated over by skate blades	W21.89	Striking against or struck by other sports equipment
W21.39	Struck by other sports foot ware	W21.9	Striking against or struck by unspecified sports equipment

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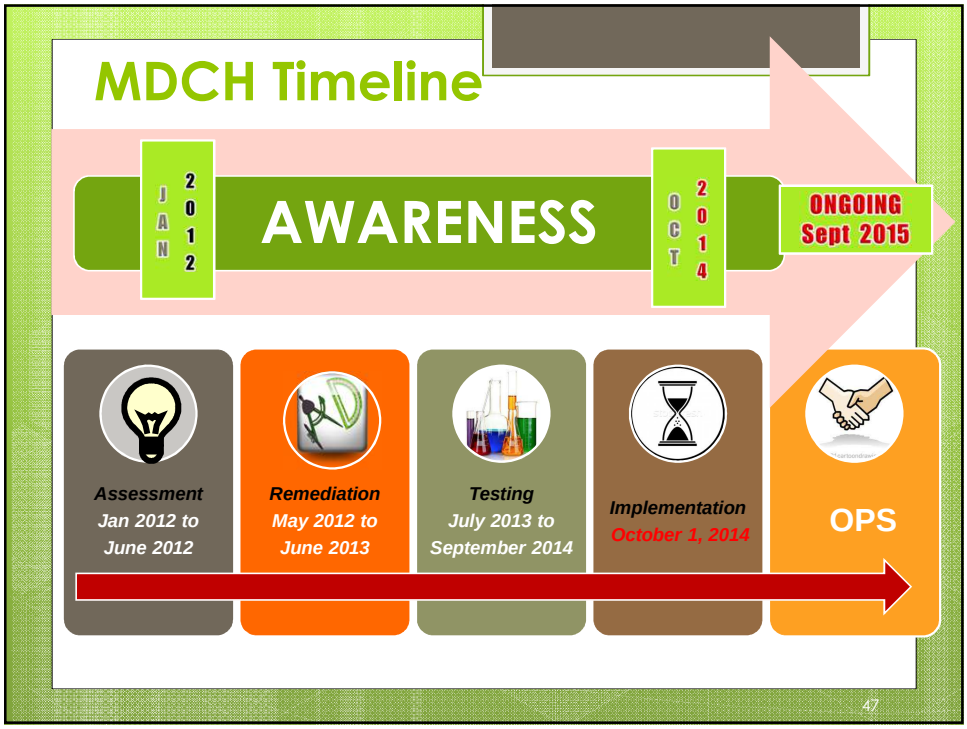
Provider Impacts

- More detailed medical documentation will be required to support the new code set
- Codes will be more specific
- Payments may be impacted by the code selected
- Provider staff must be familiar with the new coding and how it impacts your business
- CPT and HCPCS Codes will not be affected



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Take Home Message!

Preparation is the key
Successful Implementation!

Deadline October 1, 2014.

Begin preparation now!

ICD-10 Resources

- www.michigan.gov/5010icd10
  - ✓ MDCH specific information including FAQs & other links
  - ✓ GEMS Viewer
  - ✓ Email: MDCH-ICD-10@michigan.gov
  - ✓ Telephone: 1-800-292-2550
- www.CMS.gov/ICD10
- www.WEDI.org
- www.AHIMA.org/icd10
- www.BCBSM.com/icd10