The below information contains our archived provider tips from 2010/2011/2012.

2012 BILLER "B" AWARE INFORMATION

December 20, 2012: Attention Private Duty Nursing, ASC, Children Waiver, SED Waiver, Podiatry (99281-99285), MIHP Provider types: The CHAMPS problem previously posted on December 19th has been resolved and MDCH is planning to resurrect the denied claims which processed prior to this issue being resolved.

December 19, 2012: Attention ALL Providers: After the current CHAMPS update which took place over the weekend, providers will now see both "In Process" and "Suspended" claim status in CHAMPS claim inquire screens. When filtering using the filter by option, providers still only have the "In Process" selection but will return you both "in process" and "suspended" claim statuses permitting the NPI has claims in both statuses. Claims can be suspended for a multitude of reasons such as other insurance information reported on the claim, reviewing a prior authorization or EZ link documentation on file etc.

Providers can use additional filter by options of Reason code % and Remark code % to view what could be causing their claim to suspend. Providers with further questions as to what is causing their claims to suspend can contact provider support by phone#1-800-292-2550 or by email: ProviderSupport@michigan.gov

December 19, 2012: Attention Private Duty Nursing, ASC, Children Waiver, SED Waiver, Podiatry (99281-99285), MIHP Provider types: MDCH has identified a rate issue effecting the above noted provider types which may result in a delay in payment or claim being processed. MDCH is currently working on correcting the issue by possibly implementing an emergency fix within the CHAMPS system. PDN provider type claims will be suspending and manually processed by MDCH until this had been resolved.

Once this issue has been resolved MDCH will post an updated Biller B Aware to notify providers

December 11, 2012: Attention ALL Providers: Effective 12/14/12, Beneficiaries with Medicaid and Medicare that are enrolled in a Medicaid Health Plan will now have Benefit Plan ID MMEMC assigned instead of MA-MC to indicate the Managed Care enrollment for dates of service 10/01/12 ongoing. There are no changes to the benefits.

December 3, 2012: Attention ALL Providers: Due to system maintenance, CHAMPS will be down on Saturday, December 15th 2012, from 6pm to 11pm. This outage will effect CHAMPS system access for **all** functionality.

November 26, 2012: Attention ALL Providers: **Pay Cycle 48:** Inpatient Hospital providers may see a significant increase in adjusted claims on their 11/29/12 remittance advice. The MIP (Medicaid Interim Payment) indicator within the providers enrollment was incorrectly end dated and allowed the identified claims to pay instead of being MIP suppressed. MDCH has adjusted these claims to correctly allow them to pay under the MIP suppression. The affected providers received a letter advising them of why the adjustments were being done. Outpatient Hospital and Long Term Care providers may also see an increase in voided claims for the above noted pay cycle. As a large TPL (Third Party Liability) void batch was submitted as part of the normal TPL take back process for beneficiaries with other insurance which was not reported on the claim.

November 5, 2012: Attention ALL Providers: MDCH has identified claims reported with Claim Adjustment Reason Code 151 (Payment is adjusted because the payer deems the information submitted does not support this many/frequency of services) have been processed incorrectly. MDCH will be

adjusting paid claims with this Claim Adjustment Reason Code submitted on or after 9/18/2009. You will begin to seeing these adjusted claims on future RA's.

November 1, 2012: Attention Nursing Facility and Hospice Providers: When a beneficiary has a monthly patient pay amount (PPA) and a level of care (LOC) for nursing facility (02) and hospice (16) on file, the patient pay amount (PPA) will be deducted from the first claim received in CHAMPS. This will occur regardless if the PPA is located on the eligibility segment for LOC 02 or LOC 16, and the higher PPA amount will be deducted. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence, according to the level of care the beneficiary was at on the first of the month. This will prevent the PPA from being deducted from the wrong claim.

October 30, 2012: Attention Nursing Facility Providers: This is a reminder (previously posted February 28, 2012) MDCH has identified Nursing Facility room and board claims that have duplicate and/or payments for the same month. MDCH will be initiating voids in the next couple of months to return monies on claims with dates from 2009 and forward that meet this criteria.

October 29, 2012: Attention ALL Providers: Any Provider or Trading Partner who currently submits their 837 HIPAA Compliant Transaction through Champs Web Upload will need to change the file name. This will become Standard formatting for files effective December 14, 2012. By changing this now, you will not have any issues when this goes into effect. If you do not use this format, you will receive an error on your screen and the file(s) will not load. Here is a listing of correct file names:
5475(837) - Health Care Claim
5414(270) - Eligibility Inquiry
4952(276) - Claim Status Inquiry
5386(278) - Prior Authorization Inquiry

Here are examples of the naming convention depending on if you Log into Champs using an NPI or Champs Provider ID:
NPI.5475.CCYYMMDDhhmm (example: 1234567890.5475.201210261208.dat)
Champs ProviderID.5475.CCYYMMDDhhmm (example: 1234567.5475.201210261209.dat)

October 22, 2012: Attention ALL Providers: MDCH previously experienced problems loading the 9/27/12 paper Remittance Advices into archived documents for providers. This was resolved over the weekend of 10/20/12 if you are still experiencing problems finding this Remittance Advice please contact Provider Support by phone at 1-800-292-2550 or by email ProviderSupport@michigan.gov

October 18, 2012: Attention ALL Providers: FDA advises healthcare professionals to follow-up with patients who were administered any injectable medication from or produced by NECC (New England Compounding Center) including injectable ophthalmic drugs used in conjunction with eye surgery, or a cardioplegic solution purchased from or produced by NECC after May 21, 2012. Healthcare professionals and medical care organizations should inform patients who received the NECC products noted above of the symptoms of possible infection and instruct patients to contact their healthcare provider immediately if they experience any of these symptoms. The Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), and state health departments including the Michigan Department of Community Health (MDCH) are coordinating a multi-state investigation of cases of fungal meningitis and strokes among patients who received epidural steroid injections after July 1.

For more information please see the following links:

FDA Safety information:
http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm323946.htm?source=govdelivery&nbsFp;

CDC Official Health Advisory: Click Here

MDCH Website: http://www.michigan.gov/mdch/0,4612,7-132-8347-287681--,00.html

October 18, 2012: Attention ALL Providers: MDCH has identified claims reported with Claim Adjustment Reason Code 39 (Services denied at the time authorization/pre-certification was requested) have been processed incorrectly. All claims that have been paid with this Claim Adjustment Reason Code will be adjusted and processed according to policy. You will begin to see these claims on RA 10/25/2012.

October 16, 2012: Attention ALL Providers: A revision and update of the Medicaid NCCI webpage has been posted to the Medicaid.gov website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

October 8, 2012: Attention ALL Providers: As previously posted on September 27th MDCH is still experiencing issues with the Remittance Advice process and the posting of the RA's into the CHAMPS archived documents system for the 9/27/12 pay cycle date. As a current work around providers can access their paid/denied claims within CHAMPS claim inquire filter by pay cycle date 09/27/2012. Once this issue is resolved and update will be posted notifying providers.

October 8, 2012: Attention ALL Providers: Due to the high volume of claims we were unable to process all claims that came in before 9/25/12 cut off. Payments for 10/04/12 payroll date have been issued, however Remittance Advices were incomplete for some providers. The providers effected will have two remittance advices dated 10/11/12. Providers will need to match the Warrant/EFT number to corresponding remittance advice to verify payments for each payroll.

October 4, 2012: Attention ALL Providers: Due to an unexpected accounting issue while processing checks, we expect a one to two day delay in delivering EFT and Paper checks. We apologize for any inconvenience this may cause.

October 4, 2012: Attention ALL Providers: Due to an unexpected system issue with claim adjudication, approximately 25,000 claims will not be adjudicated on time for pay cycle 41 (10/11/12) and will now be paid in the following pay cycle 42 (10/18/12). We apologize for any inconvenience this may cause.

October 3, 2012: Attention Nursing Facilities: The Medicaid Provider Manual, Beneficiary Eligibility Chapter, explains that nursing facilities can obtain patient-pay amount and eligibility information from the Tentative Patient Pay Amount Notice (DHS-3227) or CHAMPS Eligibility Inquiry and/or other available eligibility options. The Medical Services Administration realizes that nursing facilities are responsible for collecting the Patient Pay Amount (PPA). A timely collection of the PPA is vital for the nursing facility as it helps eliminate the need to claim adjustment Medicaid and the need to retroactively collect the PPA from the beneficiary. A timely collection of the potential PPA is also a safeguard for the facility where problems develop with the PPAs "dropping off" Bridges. To help alleviate unneeded claim adjusting and to collect a PPA more timely, the Medical Services Administration encourages nursing facilities to determine what a potential beneficiary's PPA will be and collect that PPA prior to receiving the DHS-3227. Subsequently, the facility would bill Medicaid showing that potential PPA as determined by the nursing facility.

September 10, 2012: Attention Primary Care Practitioners: Providers who practice in primary care should select their primary specialty designation in CHAMPS. Providers may begin making this selection in CHAMPS beginning October 1, 2012. Michigan Medicaid will be utilizing the physician specialty designations and board certification information for the Affordable Care Act Primary Care Rate Incentive effective for dates of services beginning January 1, 2013.

September 7, 2012: Attention Trading Partners: The DEG (Data Exchange Gateway) will be down for maintenance on Sunday, September 16, 2012 and September 23, 2012 at 8:00 a.m. and will be back up at 5:00 p.m. During this downtime you will not be able to submit any files. Please submit your files before or after this time frame. We apologize for the inconvenience.

September 5, 2012: Attention ALL Providers: Due to intermittent connection issues with the State of Michigan Single Sign On (SSO), the States SSO will be down on September 9, 2012 from 9am until 12pm for repairs. This outage will affect all SSO applications including CHAMPS. We are sorry for any inconveniences this may cause.

August 23, 2012- Attention Trading Partners: The DEG (Data Exchange Gateway) will be down for maintenance on Sunday, August 26, 2012 from 9:00 a.m. until Noon. Please submit your files before or after this time frame. We apologize for the inconvenience.

August 22, 2012- Attention ALL Providers: Due to a migration in MDCH's FILENET database server ARCHIVED DOCUMENTS will be down and inaccessible from Friday 09/07/2012 starting at 6:00pm until Sunday 09/09/2012 at 6:00pm. We are sorry for any inconveniences this may cause.

August 22, 2012- Attention OPH Providers: Previously rejected Medicare Crossover claims (per July 26, 2012 message below) will be resurrected and should start to appear on RA 08/23/2012. (54,000 TCN's)

August 22, 2012- Attention OPH Providers: All claims paid with dates of service from 07/01/2012 through now will be adjusted with the newly loaded July APC updates and should start to appear on RA 08/23/2012. (20,800 TCN's)

August 20, 2012- Attention ALL Providers: MDCH has identified claims reported with Claim Adjustment Reason Code 151 have incorrectly denied starting with RA date 07/19/2012. MDCH will resurrect these denied claims to ensure proper adjudication. You will begin to see these claims on RA 08/23/2012.

July 30, 2012- Attention ALL Providers: Important message regarding CSHCS and Medicaid dually eligible beneficiaries: ENROLLMENT INTO MANAGED CARE. Please read L-12-26.

July 26, 2012- Attention OPH Providers: Medicare Crossovers made recent changes to no longer send the line level date of service (DOS) on OPH claims when the claim is a single line DOS per NUBC/5010/TR3 guidelines. Outpatient Claims without line level DOS sent to the CHAMPS APC/OPPS software are ungroupable which currently causes the entire claim to deny. MDCH is currently working on a fix to copy the header from/to dates of service to the line dates of service to send to the grouper software and will resurrect any denied claims for this issue once the fix is in place.

July 18, 2012- Attention Nursing Facility Providers: Room and Board claims received on or after June 22, 2012 reporting the Occurrence Code 24, are currently rejecting in error. Please wait to rebill until the problem is corrected. We will notify you immediately when the problem has been fixed.

July 17, 2012- Attention ALL Providers: When reporting primary insurance information on Medicaid secondary/tertiary claims the Claim Filing Indicator must be accurately reported to reflect the appropriate type of insurance, improper reporting may cause improper payments or your claim to deny. *Please note* that per the 837 Implementation Guide, the OF- Other Federal Program, Claim Filing Indicator should only be used when submitting Medicare Part D claims and should not be used when reporting Commercial or Federal Employee Program coverage. The inappropriate use of Claim Filing Indicators may cause claims to overpay and MDCH will initiate voids in the near future to return monies on claims with dates 2009 and forward that meet this criteria.

July 13, 2012- Attention ALL Providers: Due to the Holiday and high volume of claims we were unable to process all claims that came in before 7/2/2012 cut off. These payments will be delayed 1 week and will appear on the 7/17/2012 RA.

July 12, 2012- Attention ALL Providers: Please be advised that Procedure Code 99402 has been corrected in CHAMPS. Any claims denied from June 26 to June 28, 2012 have been resurrected (week of July 09, 2012) and do not have to be resubmitted by the provider. All claims that were suspended, per

Biller B Aware posted on June 06, 2012, have been released for payment the week of July 09, 2012. Please allow 7-14 days for your payment and remittance advice.

July 3, 2012- Attention ALL Providers: Due to Independence Day State Holiday the warrant and EFT date that would have processed Wednesday, 07/04/2012 will be processed Thursday, 07/05/2012
June 29, 2012- Attention Chiropractic Providers: On May 1, 2012 MDCH released Bulletin MSA 12-14; Reinstatement of Chiropractic Services for Medicaid Beneficiaries Age 21 and Older.
Due to a delay in implementation, the system did not update the codes until the June 22, 2012 release. This caused claims billed between June 1, 2012 and June 22, 2012 to reject. MDCH will recycle those claims on an upcoming remittance advice.

June 28, 2012- Attention ALL Providers: Please be advised that MDCH has resolved the issue in CHAMPS regarding Member Eligibility inquiries. Providers now have complete access to running eligibility.

June 26, 2012- Attention ALL Providers: CHAMPS RA date 6/21/2012 pay cycle 25 failed in the offsetting/netting process as a result there have been many receivables created and checks going out at 100% pay. This will be corrected for pay cycle 26 RA date 6/28/2012 for providers that had any offset/adjustments that should be been recouped on the 6/21/2012 Ra.

June 26, 2012- Attention ALL Providers: Please be advised that MDCH is aware of Providers experiencing issues with Code 99402 and that payment for this code has been rejected. MDCH is working toward a swift resolution. For future claims submitted with this code, please note that the claim will automatically go into a "suspend" status until this issue is resolved.

June 26, 2012- Attention ALL Providers: Please be advised that MDCH is aware that there is in issue in CHAMPS regarding Member Eligibility inquiries. Providers are experiencing difficulty running eligibility while utilizing filters ***other than*** the ***Medicaid Beneficiary ID***. We are attempting to expedite a resolution and will post an update as soon as the issue is fixed. Meanwhile, MDCH recommend Providers using other web resources, Web Dennis and MIHeatlh, until a resolution has been generated.

June 19, 2012- Attention Dental Providers: **REMINDER:** Diagnosis codes are required to be reported for all oral/maxillofacial surgery and/or anesthesiology services with dates of service on or after 1/1/2012. These requirements apply to all claim submission formats (837D, DDE and Paper claims) If the appropriate diagnosis code is not listed the claim will deny with CARC 16 and RARC MA63. For more information please see Policy Bulletin MSA-11-36 and the Medicaid Policy Manual>> Billing and Reimbursement for Dental Providers Section 5.4

June 05, 2012- Attention ALL Providers: Please be advised that due to system maintenance, EFT payments for pay cycle 23 (June 7, 2012) will be issued on Friday, June 8, 2012. Paper checks will be mailed on Thursday, June 7, 2012

May 24, 2012- Attention ALL Providers: MDCH has a Reimbursement Limitation on laboratory services rendered by the same provider, for the same beneficiary, on a single date of service. A processing error was allowing all laboratory services to be reimbursed beyond the above stated MDCH Policy Guidelines. The issue has been resolved and current claims are now being processed according to policy guidelines. Please be aware that MDCH will be reprocessing incorrectly processed claims and doing take backs on overpayments in the near future. For further information on this laboratory limitation policy, please refer to the MDCH Policy Manual at: www.michigan.gov/medicaidproviders >>Policy and Forms>> Medicaid Provider Manual>>Laboratory >>Section 3, Reimbursement Limitations.

May 24, 2012- Attention Out-of-State Providers: MDCH reimburses out of state providers who are beyond the borderland area if the service meets one of the following criteria:
Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Balanced Budget Act of 1997 and its regulations; or
Medicare and/or private insurance has paid a portion of the service and the provider is billing

MDCH for the coinsurance and/or deductible amounts; or
The service is prior authorized by MDCH. MDCH will only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas.

For further information pertaining to MDCH's policy on out of-state Providers, please refer to our Policy Manual at: www.michigan.gov/medicaidproviders >>Policy and Forms>> Medicaid Provider Manual>>General Information for Providers>>Section 7.3, Out of State/Beyond Borderland Providers. A processing error allowed payments to occur on claims that failed to meet the above outlined criteria. Please be aware that these payments will be recouped on a remittance advice in the near future.

May 07, 2012- Attention ALL Providers: Payments for pay-cycle 18 have been delayed due to an internal processing issue. The payment will be issued on Monday 05/07/2012. The remittance advice for these payments will be issued on 05/10/2012. This special remittance advice may be matched to your 05/07/2012 payment by the warrant/EFT number. Regular payments and remittance for pay-cycle 19 have not been affected and are planned to be issued in a timely fashion.

May 03, 2012- *UPDATED from 3/13: Attention Maternal Infant Health Program (MIHP) Providers: A systems issue has resulted in procedure code 99402 processing and paying the home rate of $83.72, regardless of the place of services reported on the providers claim. This issue was identified in 2009 and has now been corrected. Effective March 14, 2012 CHAMPS will begin process claims at the correct rate, based on the place of services reported. MDCH is currently reviewing the claim data related to improperly paid claims and is working on a resolution to recoup any overpayments. Please check back to Biller "B" Aware periodically for any updates on the resolution. The correct rates can be found on the MDCH fee screens at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Maternal Infant Health Program. *There are approximately 23,500 TCNs which need to be adjusted. MDCH will adjust these claims over 3 pay periods starting next week with pay cycle 19 (5/9/12). The remaining claims will be adjusted on either pay cycle 20 (5/16/2012) or pay cycle 21 (5/23/2012).

May 02, 2012- Attention Home Health Agencies: CSHCS AND REPORTING OF REFERRING PROVIDER NPI - Home Health Agencies are reminded that the NPI of the CSHCS authorized referring provider must be reported on the claim, and must be listed as an authorized CSHCS provider. The reporting of the authorized referring provider NPI will eliminate rejected claim setting the B7 reason code - CSHCS Has Not Authorized this Provider.

April 30, 2012- Attention PDN Providers: Billing for One Child When Two Have Been Authorized. A PDN authorized to provide services to two children at the same location may find that at times only one child is present to receive services. This may occur when the other child is in school, at a medical appointment, hospitalized, or on a family outing. When billing for services for one child (when two have been authorized), do not use the TT modifier along with the HCPCS code. Claims will not pay for one child unless the following comment is entered in the REMARKS Section of the claim: "Only one child present at time of service, documentation on file." The beneficiary record must document the reason why only one child was present to receive the service as well as the beginning and end time of the service.

April 26, 2012- Attention ALL Providers: There was a processing issue with Secondary claims adjudicated April 21st - April 24th that resulted in over payments due to MDCH not recognizing the Primary Insurances CARC's. The issue has been resolved and any paid claims that were impacted will be adjusted by MDCH in the near future for proper adjudication.

April 04, 2012- Attention ALL Providers: Several NDC codes were end dated in CHAMPS in error. This is now corrected. If you have a claim that has rejected with CARC 16 RARC M119 please verify you have the correct NDC on the claim. If all information is correct please rebill or

adjust as appropriate.

March 21, 2012- Attention ALL Practitioners: As a reminder, effective January 1, 2012, there was a modification to the reimbursement methodology for specific injectable drugs for the following programs: Medicaid, Children's Special Health Care Services (CSHCS) and Maternity Outpatient Medical Services Program (MOMS).This new methodology prices certain lower cost injectable drugs in classes with therapeutic alternatives at the maximum allowable cost. Utilization of lower cost alternative agents will have increased reimbursement over Average Sales Price (ASP) rates, with margins greater than or equal to higher cost agents within the same therapeutic class. Below is the list of drug classes and the drugs that will be affected by this new pricing methodology

· Anti-Emetics: Kytril and Zofran
· Bisphosphonates: Aredia
· Colony Stimulating Factors: Neupogen and Leukine
· Taxanes: Taxol

For a full listing of both higher cost agents and lower cost alternatives included in the four drug categories and for more information about the change, please see policy bulletin number MSA 11-50 (Changes in Reimbursement for Injectables - J Code Updates) on the MDCH web site located at www.michigan.gov/medicaidproviders under "Policy and Forms," then "2011."

March 21, 2012- Attention ALL Providers: Third Party Liability (TPL) sends out Pending Adjustment reports to providers when another insurance is found to be primary over Medicaid and the claim is pending to be recovered by Medicaid. These reports are sent to the provider's CORRESPONDENCE address that is listed in CHAMPS. These reports additionally are available on line in CHAMPS ARCHIVED DOCUMENTS. Many of these reports have been returned to MDCH as undeliverable. If you see that you have a report in CHAMPS and you did not receive it via Regular Mail as well, please confirm the CORRESPONDENCE address listed in the Enrollment area of CHAMPS is accurate with all information needed for proper delivery example: Dept #'s, Suite or PO BOX.

March 20, 2012- Attention ALL Providers: **MDCH Update to HIPAA 5010 Deadline;** In response to CMS's most recent extension of the 5010 enforcement period from April 1, 2012 to June 30, 2012, MDCH will be continuing as planned and **not** be accepting 4010 claims after March 31, 2012. Effective Sunday, April 1, 2012, all transactions sent to MDCH Medicaid must be in 5010 format.Transactions submitted in 4010 format will be rejected. You will not receive payment from Michigan Medicaid on any claims submitted in 4010 format. In preparation for our final change-over to 5010, we have recognized that some claims are still being submitted in the 4010 format. Please make the necessary changes needed prior to April 1, 2012 so that your claims can be adjudicated properly in the 5010 format. You must also submit data using the appropriate Application IDs for 5010. Application IDs of 4780 (for fee-for-service claims) and 4951 (for managed care encounters) used for 4010 files will be discontinued and will reject at the Data Exchange Gateway.

For those Providers who are not prepared for 5010, or will not be ready by April 1, 2012 we recommend that you submit your transactions through Direct Data Entry screens in CHAMPS. For any questions please contact us at: MDCH-5010@Michigan.gov

March 8, 2012- Attention Nursing Facility Providers: **REMINDER:** Effective 2/17/2012 Updates have been made to Nursing Facility pricing logic. Please refer to MDCH Policy Bulletin MSA 12-1 for specific pricing information.

March 8, 2012- Attention Outpatient Hospitals, Outpatient Rehabilitation Facilities, Practitioners: This is a clarification in regards to MSA 12-02 Outpatient Therapy service limitations: If therapies were started AFTER the policy implementation date of March 1, 2012, the beneficiary will be allowed 144 units in a 12 month time period. For therapies started

BEFORE this policy implementation date of March 1, 2012 only 36 visits in a 90-day time period will be the limitation. Please refer to MSA 12-02 along with the Medicaid Provider Manual for prior authorization requirements and further policy on Outpatient Therapy Services

March 5, 2012- Attention In-Patient Providers: MDCH will be reprocessing approximately 2,700 claims due to Jan/Feb 2012 DRG V29 software and pricing update.

March 5, 2012- Attention Out-Patient Providers: MDCH will be reprocessing approximately 61,000 claims due to Jan/Feb 2012 APC software and pricing update.

March 5, 2012- Attention ALL Providers: Archived documents from CHAMPS, such as Remittance Advices, will not be available for viewing or to download for a period of time beginning Friday, March 9, 2012 at 6:00 PM and ending Monday, March 12, 2012 at 7am. This is due to a system upgrade that will take place on the State of Michigan file management servers.

February 28, 2012- Attention Nursing Facility and Hospice Providers: MDCH has identified Nursing Facility and Hospice room and board claims that have duplicate payments for the same month. MDCH will be initiating voids in the near future to return monies on claims with dates from 2009 and forward that meet this criteria.

February 23, 2012- Attention Nursing Facility Providers: MDCH has identified an issue with Nursing Facility crossover ancillary claims (Part B). The coordination of benefits contractor for Medicare, Group Health Incorporated (GHI) is dropping the service line dates causing claims to process incorrectly at a $0 payment or to deny in error. Providers will need to submit a claim adjustment to correct claims that processed incorrectly, or submit a new claim for any denied claims. As soon as this problem is corrected a new Biller "B" Aware will be posted.

February 23, 2012- Attention DMEPOS and Hospice Providers: The Medical Services Administration has identified a problem with some Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims when the beneficiary is LOC 16 (hospice). DMEPOS providers must not bill Medicaid for supplies related to the treatment of the beneficiary's terminal illness. These supplies are the responsibility of the hospice and as such are included in the hospice per diem rate. Additionally, if a hospice beneficiary resides in a nursing facility (NF) most medical supplies and/or DME are considered as part of the facility's per diem rate, or may be included in the hospice per diem rate. These claims for DME/supplies are subject to denial, claim adjustment, or post payment review.

February 22, 2012- Attention Nursing Facility Providers, PACE and MI Choice Program Agencies: Please be advised that due to a system maintenance, the LOCD (Level of Care Determination) will be down Friday 02/24/2012 at 6:00 PM until Monday 02/27/12 at 6:00 AM. During this time providers will be unable to access the LOCD tool online.

February 16, 2012- Attention ALL Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns that were retroactively enrolled into a Medicaid Health Plan. Please note, as with previous quarterly newborn take backs, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. Please review the following for information on how to verify the Adjustment Source of your claim.

February 9, 2012- Attention Inpatient and Outpatient Hospital Providers: UPDATE: MDCH has re loaded the missing PDF file formats of the FD-622 reports which were previously only accessible under the CSV file type. The FD-622 should now be accessible under both file types and are loaded up to the 2/02/12 pay cycle date. The normal process for loading these files should resume with the next pay cycle date.
If you are still having trouble accessing the report please contact Provider Support by phone 1-

800-292-2550 or by email ProviderSupport@michigan.gov subject: FD-622.

February 8, 2012- Attention Nursing Facility Providers: When reporting Value codes 80, 81 or 82, report the actual number of days without additional zeros. For example; when reporting 30 covered-days, report value code 80 with 30 (not 3000).
February 7, 2012- Attention Nursing Facility Providers: MDCH has identified an issue with Nursing Facility crossover therapy claims (Part B). The patient pay amount is setting against ancillary charges (Part B) in error. As soon as this issue is corrected a new Biller B Aware will be posted.

February 1, 2012- Attention Inpatient and Outpatient Hospital Providers: FD-622 Information

February 1, 2012- Attention Nursing Facility Providers: MDCH has identified an issue with crossover claims (Medicare Part A) which are paying zero dollars. Upon system correction all affected claims will be re-pro

January 31, 2012- Attention ALL Providers: Due to a migration in MDCH's email system, there may be a delay in response to emails submitted to: Provider Outreach, Provider Enrollment and Provider Support email addresses. We appreciate your patience during this transition.

January 17, 2012- Attention ALL Providers: Benefit Plan ID NEMT Clarification: The eligibility response now returns a Benefit Plan ID NEMT (Non-Emergency Medical Transportation) which is assigned for Medicaid beneficiaries that reside in Wayne, Oakland, and Macomb Counties. Logisticare is responsible for transportation when the beneficiary qualifies and has no other means of transportation to access services. Please see bulletin: MSA 10-56 for more information.

January 12, 2012- Attention Dental Providers: **REMINDER:** Diagnosis codes are now required to be reported for all oral/maxillofacial surgery and/or anesthesiology services with dates of service on or after 1/1/2012. These requirements apply to all claim submission formats (837D, DDE and Paper claims) If the appropriate diagnosis code is not listed the claim will deny with CARC 16 and RARC MA63. For more information please see Policy Bulletin MSA-11-36 and the Medicaid Policy Manual>> Billing and Reimbursement for Dental Providers Section 5.4

January 04, 2012- Attention Nursing Facility Providers, PACE and MI Choice Program Agencies: This is a reminder that the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) must be conducted only for Medicaid eligible or Medicaid pending beneficiaries and it must be conducted within the time frames stated in Medicaid policy. Please note that failure to conduct the LOCD in accordance with Medicaid policy will result in the denial of a Medicaid claim. The LOCD policy is located in the Medicaid Provider Manual at http://www.michigan.gov/mdch > Providers > Providers > Medicaid > Policy and Forms > The Medicaid Provider Manual.

January 03, 2012- Attention Inpatient and Outpatient Hospital Providers: MDCH is aware of a current issue with FD-622 reports not being viewable within the PDF file type format. Until the PDF file type format is available the reports are still available within the CSV file type format. Instructions for viewing the report in this format are available under the previous Biller "B" Aware message posted December 8, 2011. Outpatient Hospitals please be aware that the majority of the FD-622 report for pay cycle date 12/08/11 were unable to load into CHAMPS archived documents. MDCH is also working on reloading these reports so they are accessible to providers. Please continue to check your archived documents for updates as once the reports are re loaded they will be accessible.

2011 BILLER "B" AWARE INFORMATION

December 28, 2011- Attention ALL Practitioners: Effective January 1, 2012, there will be a modification to the reimbursement methodology for specific injectable drugs for the following programs: Medicaid, Children's Special Health Care Services (CSHCS) and Maternity Outpatient Medical Services Program (MOMS).

This new methodology prices certain lower cost injectable drugs in classes with therapeutic alternatives at the maximum allowable cost. Utilization of lower cost alternative agents will have increased reimbursement over Average Sales Price (ASP) rates, with margins greater than or equal to higher cost agents within the same therapeutic class. Below is the list of drug classes and the drugs that will be affected by this new pricing methodology

- Anti-Emetics: Kytril and Zofran
- Bisphosphonates: Aredia
- Colony Stimulating Factors: Neupogen, and Leukine
- Taxanes: Taxol
- For more information about the change, please see policy bulletin # MSA 11-50 on the MDCH web site located at www.michigan.gov/medicaidproviders >> Policy and Forms >> 2011

December 20, 2011- Attention Nursing Facility Providers: MDCH will be reprocessing over 1,600 claims that were processed incorrectly. These claims involve Medicare Coinsurance Days billed to Medicaid where Occurrence Span Code 70 (Qualifying Stay Dates for Skilled Nursing Facility- SNF) was not reported. Bulletin MSA 10-03 referenced the use of Occurrence Span Code 70 which aligns with the National Uniform Billing Committee (NUBC).

December 8, 2011- Attention Nursing Facility Providers: MDCH is finalizing a modification to the reimbursement methodology for Medicare Advantage Plan Co-Insurance Days. These claims may have originally been processed incorrectly. Once the modification is complete, MDCH will reprocess the affected claims on behalf of providers.

December 5th 2011- Attention Professional Providers: Effective January 1, 2012, there will be a modification to the reimbursement methodology for specific injectable drugs. This new methodology prices certain lower cost injectable drugs in classes with therapeutic alternatives at the maximum allowable cost. Utilization of lower cost alternative agents will have increased reimbursement over Average Sales Price (ASP) rates, with margins greater than or equal to higher cost agents within the same therapeutic class. This new methodology represents an opportunity for increased reimbursement. For additional information including the drugs and the programs affected, please see Policy Bulletin MSA-11-50

November 30, 2011- Attention All Providers and Billing Agents: Though CMS recently announced it will not be enforcing penalties for non-compliance of the HIPAA 5010 version, MDCH would like to clarify Michigan Medicaid's position.

MDCH does not see this as an exception to being compliant and will be requiring a full implementation to HIPAA 5010 standards on January 1, 2012.

November 30, 2011- Attention Outpatient Hospital Providers: MDCH will be reprocessing approximately 18,000 claims due to October APC software and pricing update.

November 22, 2011- Attention FQHC and RHC Providers: When completing the Health Plan detail for your Reconciliation Reports, you must report the Medicaid or MIChild issued Beneficiary ID number so eligibility can be verified. Any claim submitted for a beneficiary not enrolled with a Health Plan during that reported date of service will be excluded from your settlement.

November 16, 2011- Attention ALL Billing Agents: Effective mid-August MDCH changed and reposted a new 835 Electronic Remittance Advice Request for Billing Agent Change/Update form at the following link:

http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42545_42638---,00.html If you book marked or saved the form previously, prior to the dates above, please use this link to obtain the correct form.

When having providers fax that form to Automated Billing for processing, please use this new version. MDCH needs to have consistent information being received from all sources regarding this new 835 form.

November 9, 2011- Attention ALL Providers: Due to the implementation of HIPAA 5010, CHAMPS will experience a complete system outage beginning at 12am Friday December 30th, 2011. The system is scheduled to be back up and functional on Tuesday January 3rd, 2012 at 12am. During this 4 day outage, you will not be able to access the CHAMPS system at all.

Additionally, the last opportunity to submit a HIPAA 4010 file will be on Wednesday December 28th, 2011 at 3pm. After that only HIPAA 5010 claims will be accepted and any submitted after Wednesday December 28th, 2011 will be held during the outage and will be processed beginning on at 12am January 3rd, 2012.

To check eligibility, we suggest you use web-Denis or the Michigan Public Health Institute's (MPHI) web service for beneficiary eligibility status. An L-Letter will be published soon with further details about the CHAMPS system outage.

For questions regarding the HIPAA 5010 implementation please go to www.michigan.gov/medicaidproviders >> HIPAA 5010/ICD10 Implementation or email MDCH-5010@michigan.gov .

November 7, 2011- Attention ALL Providers: All major identified CHAMPS defects have now been fixed and released into CHAMPS production in an effort to prepare for the January 1, 2012 implementation of HIPAA 5010. Please reference the CHAMPS Provider Update Table for a current list of system fixes. The CHAMPS Provider Update Table can be found at www.michigan.gov/medicaidproviders >> CHAMPS>> CHAMPS Provider Update Table.

For those of you who have been holding batches of claims, due to system defects, and have now exceeded timely filing limits, please submit a request for timely filing bypass/acceptance no later than 12/1/2011 to ProviderSupport@michigan.gov with the subject line: CHAMPS BATCH TIMELY DEFECTS. Please include in the body of the email the total claim count to be submitted, the range of dates of service, and an explanation for the request. All batch requests will be reviewed by MDCH for validity. Upon approval response from MDCH, batches may be submitted applicable to outstanding claims previously withheld due to system defects/issues, whereby MDCH will consider for bypass of the timely filing edit.

November 3, 2011- Attention ALL Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns who were retroactively enrolled into a Medicaid Health Plan. Please note, as with previous quarterly newborn take backs, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. Please review the following for information on how to verify the Adjustment Source of your claim .

November 1, 2011- Attention Vision Providers: MDCH has identified a systems issue that has caused claims for beneficiaries age 21 and older to deny incorrectly (e.g., RARC N129). This error has been corrected and claims will be adjusted by MDCH. Providers will see these claims on their remittance advice during November 2011.

October 31, 2011- Attention ALL Providers: **Reminder** : A primary care provider (i.e., MD, DO) or other Medicaid-approved provider (i.e., Certified Nurse-Midwife [CNM], Nurse Practitioner [NP]) can provide family planning/Plan First services. Beneficiaries eligible for this waiver are limited to the receipt of family planning services only. Family planning services are defined as any medically approved means, including diagnostic evaluation, medications, and supplies, for voluntarily preventing or delaying pregnancy. Covered services include:

- Office visits for family planning related services. This includes preventive evaluation and Management office visits and other office/outpatient visits for family planning services.
- Contraceptives, including oral contraceptives and injectables.
- Contraceptive supplies and devices for voluntarily preventing or delaying pregnancy.
- Laboratory testing and pharmaceuticals related to contraceptive management or initial treatment of sexually transmitted infections (STIs).
- Sterilizations completed in accordance with current Medicaid policy.

PLEASE NOTE: Family planning/Plan First services are limited to the V25 diagnosis code series range. Providers must enter the appropriate V25 diagnosis code as the primary diagnosis on the claim form for services rendered.

October 25, 2011- Attention ALL Providers: Effective January 1, 2012, all trading partners must submit electronic healthcare transactions using the HIPAA 5010/NCPDP D.0 transaction formats. (Trading partners include: providers, clearinghouses, billing agents, vendors, and health plans.) **B2B testing is now available for all trading partners through the Ramp Manager testing website at** https://sites.edifecs.com/index.jsp?michigan**. All trading partners must test and be certified through the MDCH two-stage B2B testing process in order to successfully submit 5010/NCPDP D.0 transactions to CHAMPS**. If you are not certified to submit 5010 transactions, **your claims will not be accepted and payments will not be processed.** Please see MSA 11-36.

October 25, 2011- Attention Nursing Facility Providers: MDCH is now accepting institutional crossover claims from the coordination of benefits contractor, Group Health Incorporated (GHI). The institutional nursing facility crossover claim process will allow nursing facilities to submit a single claim for residents dually eligible for Medicare and Medicaid.

After processing the Medicare portion, GHI will forward the claim to Michigan Medicaid for processing and reimbursement. Once Medicare payment is received by the facility and Remark Code MA07 appears on the Medicare RA, the claim should appear on the Medicaid RA within 30 days. The facility may check claim status online through the Community Health Automated Medicaid Processing System (CHAMPS). If the claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDCH showing all of the Medicare payment information.

October 19, 2011- Attention DME Providers: Per Biller "B" Aware posted May 9th & August 22 2011, MDCH has issued voids for over 10,000 claims.

October 17, 2011- Attention Outpatient Hospital Providers: MDCH has identified an issue with G0434 which was paying zero dollars prior to the CHAMPS release on September 9th, 2011. After the release G0434 was denying in error as per MSA policy bulletin 10-65 this is a covered code. MDCH will be reprocessing the affected claims.

October 10, 2011- Attention Home Health Providers : MDCH will be reprocessing approximately 3700 claims that were billed with G0151, G0152 G0153, G0154, G0156, 99601 and 99602 and were not processed correctly.

October 5, 2011- Attention Nursing Facility Providers: THE NURSING FACILITY INSTITUTIONAL CROSSOVER CLAIM PROCESS IS DELAYED UNTIL OCTOBER 10, 2011 - OCTOBER 17, 2011 AT THE LATEST.

The Michigan Department of Community Health apologizes for this delay and inconvenience. Medicaid Bulletin MSA 11-32, issued August 1, 2011 indicated that in fall 2011 that the Michigan Department of Community Health (MDCH) would be accepting nursing facility institutional crossover claims from the coordination of Medicare benefits contractor, Group Health Incorporated (GHI).

In September 2011, notice was issued on Medicaid LISTSERVE and Biller "B" Aware advising nursing facilities that effective October 1, 2011, MDCH would begin accepting crossover claims from GHI.

Any questions regarding this message can be directed via e-mail to: ProviderSupport@michigan.gov . Please include your name, affiliation, and phone number. Nursing facilities may also phone toll-free 1-800-292-2550.

October 5, 2011- Attention ALL Providers- MDCH will be reprocessing approximately 12,000 PAID claims for beneficiaries that have dual Benefit Plans, MA-ESO and CSHCS or MA-ESO and MOMS. If your claims denied for this reason, you must rebill your claim. These claims may have originally been processed incorrectly.

October 5, 2011- Attention Outpatient Providers - MDCH will be reprocessing approximately 21,000 claims due to April/ July APC software and pricing update.

September 28, 2011- Attention Hospital Providers: MDCH is pleased to announce the availability of the FD-622 Reports in a downloadable electronic format (pdf). The reports will be available for pay date cycles after October 1, 2011. In order to achieve savings, effective October 1, 2011 MDCH will cease to mail paper copies of the FD-622 to inpatient hospital, outpatient hospital, end stage renal dialysis centers, and outpatient rehabilitation facilities.

The reports are available through CHAMPS archived documents.

If you have difficulty accessing the report, please call provider hotline for assistance.

September 26, 2011- Attention ALL Providers: Revised Benefit Plan Handout with Service Type Codes *Updated 9/2011

September 21, 2011- Attention Nursing Facilities: Medicare - Medicaid Nursing Facility Crossover Claims with Group Health Incorporated (GHI) (Coordination of Benefits)

Medicaid Bulletin MSA 11-32, issued August 1, 2011 indicated that in fall 2011 that the Michigan Department of Community Health (MDCH) would be accepting nursing facility institutional crossover claims from the coordination of Medicare benefits contractor, Group Health Incorporated (GHI).

This notice is to advise nursing facilities that effective October 10, 2011, MDCH will begin accepting crossover claims from GHI. As such, claims that include Medicare as the primary payer and Medicaid as the secondary payer, will be crossed over to Medicaid from GHI.

To avoid duplicate claim rejections and delay in payment, nursing facilities must avoid direct billing to Medicaid. Medicaid asks that nursing facilities await their Medicare RA for claim submission dates effective October 10, 2011. Once Medicare payment is received by the facility and Remark Code MA07 appears on the Medicare RA, the claim should appear on the Medicaid RA within 30 days.

The following website provides more information and frequently asked crossover question: www.michigan.gov/medicaidproviders>>Billing and Reimbursement >>Medicare Crossover.

Any questions regarding this message can be directed via e-mail to: providerSupport@michigan.gov. Please include your name, affiliation, and phone number. Nursing facilities may also phone toll-free 1-800-292-2550.

September 8, 2011- Attention ALL Providers: MDCH has scheduled Michigan Medicaid Trainings and Champs Navigational sessions in the Upper Peninsula, Marquette MI during the last week of September 2011.

These sessions will offer specific training to providers with an opportunity to have a one on one session with a Medicaid Provider Liaison (note: one on one session time may be limited based on number of registered providers). To register for an AM or PM session, visit our training website at www.michigan.gov/medicaidproviders>> Communication and Training >> Medicaid Provider Training Sessions.

August 30, 2011- Attention Outpatient Hospital Providers: Outpatient Hospital Providers with service lines denied with Reasons code 11 and Remark code N10 - may wish to adjust or re-bill their claim with documentation supporting the medical necessity of the procedure code. The documents should be sent into EZ LINK and should include: Ultrasound, MRI, CAT scan, History and Physical, ER Report.

August 30, 2011- Attention ALL Providers: Providers may wish to re-bill for TPL take backs done in error but have dates of service over one year old. Please indicate in the remarks/comments section of your invoice the TCN/pay-cycle date of the void transaction that TPL used to take back the money.

Example: (4111xxx8xxxxxxx000 / pay-cycle date 08/25/2011 TPL take back in error)

The re-bill is due within 365 days from the date of the TPL take back done in error. Information supplied on the invoice will be verified.

August 29, 2011- Attention Professional Providers: MDCH has identified an issue with the reimbursement rates for the CPT codes activated for January 2011, as listed in Bulletin MSA 10-65. Rates have been re-calculated to reflect CMS's updated National Physician Fee Schedule Relative Value File for dates of service on or after January 1, 2011. MDCH has posted a revised Practitioner and Medical Clinic Database and will be reprocessing the affected claims on behalf of the providers.

Professional Providers are also advised that payment status indicators related to CPT procedure codes (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.) can be referenced at the CMS website: http://www.cms.gov/apps/physician-fee-schedule/overview.aspx .

August 22, 2011- Attention ALL Providers and Billing Agents: With CHAMPS provision for automated/electronic processes, the Automated Billing phone number (877-672-3483) has been disconnected. You can reach Electronic Data Interchange (EDI) support services/Automated Billing for any questions or issues about electronic transactions with Medicaid by e-mail at AutomatedBilling@Michigan.gov.

August 22, 2011- Attention DME Providers: UPDATED MDCH has identified a problem with claims that were incorrectly paid to DME providers when the Beneficiary has LOC 02 (Nursing Facility). Medical supplies, accessories, and durable medical equipment necessary to achieve the goals of the beneficiarys plan of care are included in the Nursing Facilitys per diem rate and are not payable to DME providers. MDCH will begin voiding these claims August 22, 2011.

August 17, 2011- Attention ALL Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns who were retroactively enrolled into a Medicaid Health Plan. Please note, as with previous quarterly newborn take backs, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. Please review the following for information on how to verify the Adjustment Source of your claim .

August 12, 2011- Attention Nursing Facilities: Long-Term Care Insurance- The Coordination of Benefits Chapter in the Medicaid Provider Manual states that federal regulations require all identifiable resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a Medicaid beneficiary has long-term care insurance, it is recognized as another resource and that resource must be billed prior to billing Medicaid.

In the event the facility is aware that a beneficiary has another resource (including long-term care insurance) but the resource is not reflected on the mihealth card or the Community Health Automated Medicaid Processing System (CHAMPS) eligibility inquiry, the facility must fill out form DCH-0078. This form can be found online at www.michigan.gov/medicaidproviders>> Policy and Forms >> Forms. The preferred method of submission is by fax to Medicaid Third Party Liability (TPL) at: 517-346-9817. While fax is preferred, the form may also be sent via e-mail to tpl@michigan.gov The form should be submitted before billing Medicaid. If known, please include the policy's per diem payment amount in the comments section of the form. Medicaid TPL will verify the information provided and update the beneficiary's CHAMPS eligibility information accordingly. The facility should bill the other resource first. Once payment has been received, the facility may bill Medicaid. The billing to Medicaid must include the payment amount received from the other resource.

August 5, 2011- Attention ALL Providers: MDCH will be reprocessing approximately 4000 claims that were billed with Modifier 54 and were not processed correctly.

August 4, 2011- Attention ALL Providers: Per Biller "B" Aware posted July 19 2011, MDCH has identified a systems issue that is causing claims to deny incorrectly with Limit or Duplicate Edits. (IE: CARC 18, B5, B13, RARC B130, N10). Claims are setting these edits against different provider types in error. MDCH has corrected this error and claims will be adjusted by MDCH on a future remittance advice.

July 29, 2011- Attention Inpatient Hospital Providers: Subsequent to the June 2011 CHAMPS release it has been reported that our MIP suppression rules have been overlooked for Medicare covered claims. Upon system correction all affected claims will be re-processed. As soon as this problem is corrected a new Biller B Aware will be posted.

July 27, 2011- Attention ALL Providers: The issue with the TPL Recovery Letters within the Archived Documents link in CHAMPS has been resolved. Providers should now be able to access these documents directly in CHAMPS.

July 27, 2011- Attention DMEPOS Providers: When billing equipment and supplies that must be reported as a daily rate (by entering total number of days used as units); it is recommended that providers use "span" dates. For example: S5498 (home infusion therapy catheter care/maintenance). If dates of service are July 15, 2011 through August 13, 2011; the dates should be reported using the "From" and "To" dates of 07/15/2011 - 08/13/2011 and report 30 units.

July 26, 2011- Attention ALL Providers: MDCH has identified that Providers are unable to access the TPL Recovery Letters within the Archived Documents link in CHAMPS. Please continue to check this site for an update on when this issue has been resolved. In the interim, all reports continue to be mailed to the correspondence address within the Provider Enrollment file.

July 25, 2011- Attention Nursing Facility Providers: MDCH has identified claims denying Reason Code 18 and Remark code N185 on some lines for ancillary services, once the system has been corrected the claims will be adjusted by MDCH.

July 19, 2011- Attention ALL Providers: MDCH has identified a systems issue that is causing claims to deny incorrectly with Limit or Duplicate Edits. (IE: CARC 18 B5 B13 RARC B130 N10). Claims are conflicting against different provider types in error. Please review the claim limit list at the line level in the Inquire Claim screen detail to confirm whether a claim has been affected by this error. As soon as this problem is corrected a new Biller B Ware will be posted.

June 30, 2011- Attention Outpatient Hospital Providers: MDCH has identified a systems issue with codes G0380-G0384 and G0379. MDCH reprocessed approximately 4000 affected claims and providers should see those claims on their remittance advice dated June 30th.

June 27, 2011- Attention ALL Providers: MDCH has identified an issue with some claims from Tuesday, 6/21 which were submitted prior to the cut off time of 4 p.m. It appears the claims, were received within the correct time frame, however did not complete processing in Champs. The issue has been addressed and these claims should be released by next pay cycle. There is no need to resubmit any claims.

June 21, 2011- Attention Inpatient Hospital Providers: With the July 1st implementation of the Present on Admission requirement - Providers need to submit POA values on IPH claims.

June 20, 2011- Attention ALL Providers: Effective August 1st, 2011 the Department of Technology, Management and Budget (DTMB) will be implementing new password policies for all users that access the Single-Sign On (SSO) web portal for the CHAMPS system. All users will be required to change their passwords to the new configuration when their existing password expires. The new password configuration/requirement is:

1. **Minimum password length is eight (8).**
2. **Password must contain at least one letter and one number.**
3. **Passwords are case sensitive.**
4. **Maximum number of repeated characters is two (2).**
5. **Password cannot be same as userid or user name.**
6. **New password cannot be same as current password.**

The SSO New Password Configuration instructions can be found on the MDCH website www.michigan.gov/medicaidproviders >>CHAMPS >>RESOURCES

June 16, 2011- Attention ALL Providers: Beginning in July 2011, The Third Party Liability (TPL) Division will be completing claim voids on claims where Blue Cross Blue Shield coverage has been identified after the claim has been processed by Michigan Medicaid.

Providers should begin to see these on the BCBS recovery reports, which will be available in early July

2011 through the Archived Documents link. Providers will have 30 days to contact TPL if you have reason to believe that the claim void should not be completed by MDCH. After 30 days, the claim will be voided in CHAMPS and providers are expected to bill BCBS as primary and re-bill MDCH as the secondary payer if necessary.

The recovery reports are available in CHAMPS >> MY INBOX >> ARCHIVED DOCUMENTS >> in the Document TYPE field select: TPL RECOVERY

June 13, 2011- Attention ALL Providers: **UPDATED** Archived documents from CHAMPS, such as Remittance Advices, will not be available for viewing or download for a period of time beginning Thursday, June 16, 2011 at 7:30 PM and ending Friday, June 24, 2011. This is due to a system upgrade that will take place on State of Michigan file management servers.

June 8, 2011- Attention ALL Providers: The Third Party Liability (TPL) Division will be issuing claim adjustments/voids on claims where they have found another payer as primary over Michigan Medicaid. Prior to these adjustments/voids being done, TPL will mail a recovery report to the providers Correspondence Mailing address on file. These letters will also be available in CHAMPS >>>MY INBOX>>> ARCHIVED DOCUMENTS >>>>in the Document TYPE field select: TPL RECOVERY

*Only contact TPL regarding adjustments if you have received a letter and are questioning the TPL recovery

If you are inquiring on an adjustment on your remittance advice, please click here for instructions on how to verify Adjustments Source.

June 6, 2011- Attention Home Health Providers: MDCH has identified a problem with claims processing incorrectly for Home Health Visits. Overpayments have been identified on procedures G0151, G0152 G0153, G0154, G0156, 99601 and 99602. Per Michigan Medicaid Policy providers can report up to two visits on the same day (i.e., two visits on the same day must be billed on individual lines of the same claim). MDCH will be initiating adjustments in the near future for all claims that did not meet this criteria.

June 3, 2011- Attention Outpatient Hospital Providers: MDCH has identified a systems issue with procedure code Cxxxx billed with revenue code 027x denying with Remark code N56 (Procedure code billed is not correct/valid for the services billed or the date of service billed.). MDCH will reprocess the affected claims on behalf of providers after the error has been resolved.

June 2, 2011- Attention Hospital Providers: Providers should note that without proper consent forms for sterilizations (current Medicaid beneficiary or possible retro-eligible beneficiary) they run the risk of non-payment.

June 1, 2011- Attention Outpatient Hospital Providers: MDCH has identified a systems issue with codes G0380-G0384 and G0379. MDCH will reprocess the affected claims on behalf of providers.

June 1, 2011- Attention Outpatient Hospital Providers: MDCH has identified a systems issue with codes Q2035-Q2039. MDCH will reprocess the affected claims on behalf of providers after the error has been resolved.

May 18, 2011- Attention Professional Providers: Subsequent observation care codes 99224, 99225, 99226 are currently non-covered services based upon current Medicaid policy. Medicaid covers physician services for beneficiaries admitted and discharged from observation status in the hospital setting for a stay less than 24 hours.

All nationally recognized codes are added to the CHAMPS reference file --with activation only as applicable to the Medicaid program's implementation of the State Health Plan and policy. Medicaid, as a state governed program, has different eligibility requirements and offers different benefits from the federally governed Medicare. While the two separate programs share many similar regulatory requirements, the Medicaid program does operate within federal guidelines.

May 9, 2011- Attention DME Providers: MDCH has identified a problem with claims that were incorrectly paid to DME providers when the Beneficiary has LOC 02(Nursing Facility). Medical supplies, accessories, and durable medical equipment necessary to achieve the goals of the beneficiarys plan of care are included in the Nursing Facilitys per diem rate and are not payable to DME providers. MDCH will be initiating voids in the near future for all claims that meet this criteria.

April 29, 2011- Attention ALL Providers: MDCH has issued voids on claims paid in error for beneficiaries that had MA-ESO (emergency services only) benefit plans. These claims did not meet the emergency criteria and originally should have been denied. Beneficiaries that have dual Benefit Plans, MA-ESO and CSHCS or MA-ESO and MOMS may have been voided in error by MDCH. MDCH is aware there are still claims not processing correctly with the Benefit Plans listed above and is currently working to resolve the issues in a future release. MDCH will post the information when corrected on our website and via ListServ message. For instructions on how to sign up for the LIST SERV notifications please go to the website at www.michigan.gov/medicaidproviders and click on >>> LISTSERV SUBSCRIPTION INSTRUCTIONS <<<

April 14, 2011- Attention MIHP Providers: MDCH inadvertently initiated newborn recovery take backs on services provided by MIHP providers. Unfortunately, there is no way for CHAMPS to reverse this error so the claims can not be resurrected or reprocessed internally. MDCH is asking providers to re-bill the affected claims. Please add the following note to your claims to expedite processing of the affected claims: **newborn void error.**

April 4, 2011- Attention ALL Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns who were retroactively enrolled into a health plan with dates of service on or after 06/01/2009 paid through 09/30/2010. Note: This quarterly batch is larger than previous batches as MDCH has not done a quarterly recovery since September 2009 due to CHAMPS go live and associated defects. Recoveries started on Pay Cycle 13. Please note, as with previous quarterly newborn take backs, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. If you have questions regarding specific claims or need assistance, please contact MDCH Provider Inquiry at (800) 292-2550 or via e-mail at ProviderSupport@michigan.gov.

April 1, 2011- Attention DMEPOS and Hospice providers: The Medical Services Administration has identified a problem with some Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims when the beneficiary is LOC 16 (hospice). DMEPOS providers must not bill Medicaid for supplies related to the treatment of the beneficiary's terminal illness. These supplies are the responsibility of the hospice and as such are included in the hospice per diem rate. Additionally, if a hospice beneficiary resides in a nursing facility (NF), claims for DME/supplies are subject to denial or post payment review because most medical supplies and/or DME are considered as part of the facility's per diem rate, or may be included in the hospice per diem rate.

March 15, 2011- Attention Professional Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns who were retroactively enrolled into a health plan with dates of service on or after 06/01/2009 paid through 09/30/2010. Note: This quarterly batch is larger than previous batches as MDCH has not done a quarterly recovery since September 2009 due to CHAMPS go live and associated defects. Recoveries will begin on Pay Cycle 13. Please note, as with previous quarterly newborn takebacks, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. If you have

questions regarding specific claims or need assistance, please contact MDCH Provider Inquiry at (800) 292-2550 or via e-mail at ProviderSupport@michigan.gov.

March 10, 2011- Attention ALL Providers: IMPORTANT NOTICE on Claim Adjustment Reports

February 23, 2011- Attention Critical Access Hospital Providers: MDCH has identified an issue with duplicate paid claims in error.

ISSUE: CAH Providers are billing their professional charges on the institutional claim using the Professional Fee Revenue Codes in error. MDCH is paying both the professional fee revenue code service line(s) in addition to the facility charge service lines for same the service which is causing duplicate payments.

RESOLUTION: For the interim solution and to prevent duplicate payments, MDCH will be issuing VOIDS for all claims paid in error. Once the voided claim appears on your Remittance Advice, providers can resubmit the claims properly. Providers must bill professional fees on a professional claim and institutional fees on institutional claim to receive appropriate payment.

February 16, 2011- Attention Inpatient Providers: There were some technical issues with DSH payments that have been resolved. Providers should receive their payments by the 22nd or 23rd.

February 16, 2011- Attention Nursing Facility Providers: MDCH has identified an issue with Nursing Facility Therapy claims that processed at an incorrect rate. MDCH is currently collecting the data necessary to reprocess the affected claims on behalf of the providers. This will affect all Nursing Facility Therapy claims from dates of service 07/01/09 and forward. These claims will be reprocessed using the most current claims logic. If your claim was previously processed under the outdated logic, it will now be adjudicated based on current CHAMPS editing.

February 14, 2011- Attention Medicaid Inpatient and Outpatient Providers: MDCH has identified an issue with duplicate claims. Providers are submitting secondary claims when Medicare is the primary payer to Michigan Medicaid and the same claim also comes to Medicaid through the Crossover process. Medicaid will process crossover claims first and deny any duplicate claim received directly from the provider. We would like to remind all providers: **Please do not submit duplicate claims.** If the Medicare crossover claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDCH showing all of the Medicare payment information.

January 27, 2011- Attention Ambulance Providers: MDCH is reprocessing all denied transportation claims with valid diagnosis codes for Health Plan beneficiaries. Ambulance Providers are also reminded to review the policy manual for the reporting of Multiple Transports per Beneficiary, specifically the requirements regarding Modifier 22 and the detailing in remarks or via an EZ-link attachment.

January 27, 2011- Attention Hospice Providers: Hospice claims are being submitted with Value Code 66 to report the Patient Pay Amount (PPA). Although this was acceptable under legacy, CHAMPS does not accept the use of Value Code 66 to report the PPA. Per the National Uniform Billing Committee (NUBC), Value Code 66 is only to be used when reporting the Medicaid Spend Down Amount (Deductible). **Value Code D3, Patient Estimated Responsibility, must be used to report the PPA.**

January 24, 2011- Attention ALL Providers: MDCH will be reprocessing 250,000 professional claims that were processed incorrectly due to an age calculation issue. MDCH will also be reprocessing approximately 200,000 outpatient Medicare secondary claims that were processed at an incorrect payment since CHAMPS go live.

These claims will be reprocessed using the most current claims logic. If your claim was previously processed under the outdated logic, it will now be adjudicated based on current CHAMPS editing. This may cause some claim lines that previously paid to reject, requiring the provider to add additional information and resubmit as new or an adjustment claim. For example: if claim paid in 2010 without a NDC and there was an issue with the age calculation; the newly reprocessed claim may now deny because the NDC was not originally reported.

January 20, 2011- Attention Professional Invoice Providers: MDCH is attempting to resolve outstanding issues regarding the processing and payment of Medicare crossover claims in the upcoming releases. For the January 21 release, MDCH plans to implement changes to the logic which will allow procedure codes covered by Medicare but not covered by Medicaid to process through the system (CARC 204 & RRC N30 will no longer post).

However, as a result of this update, some claims will deny with CARC 8 & RRC N65. These denials will be reprocessed by MDCH after Friday January 25, 2011 when the logic is updated in CHAMPS.

Furthermore, MDCH will be making additional changes on March 4, 2011 to allow Medicare Crossover claims suspended with CARC 133 to process without manual review. Claims which have been paid at a decreased rate due to limit quantities will pay appropriately (CARC B5, RRC N10 or N130).

Please see the provider update table for modifications to this schedule.

January 19, 2011- Attention ALL Providers: Beginning in early spring 2011, The Third Party Liability (TPL) Division will be completing claim adjustments/voids on claims where Blue Cross Blue Shield coverage has been identified after the claim has been processed by Michigan Medicaid.

This adjustment/void process will begin with a small batch of inpatient hospital claims and providers should begin to see these on the inpatient BCBS recovery reports, which will be mailed in early February 2011. Providers will have 30 days to contact TPL if you have reason to believe that the claim adjustment/void should not be completed by the MDCH. After 30 days, the claim will be voided in CHAMPS and providers are expected to bill BCBS as primary and re-bill MDCH as the secondary payer if necessary. TPL expects to automate this process for inpatient providers beginning in March 2011, which will void claims in April 2011. Additional provider types will be added in the future as TPL moves towards this BCBS claim adjustment/void process.

January 10, 2011- Attention ALL Providers: All providers should contact Third Party Liability (TPL) to report any changes (including new coverage or terminations) in other insurance information **prior to submitting a claim to Medicaid**.

All requests should be processed by TPL within 10 business days. After the information has been updated, the claim can then be submitted with the appropriate other insurance information reported, thus avoiding unnecessary suspends because the other insurance information has been properly updated in CHAMPS.

Please submit all requests to TPL by completing the DCH-0078 form found on the TPL website at www.michigan.gov/medicaidproviders >>Billing and Reimbursement>>Third Party Liability>> Health Insurance. Fax the completed form along with any supporting documentation to 517-346-9817 (preferred option) or email the form to TPL@michigan.gov.

2010 BILLER "B" AWARE INFORMATION

December 21, 2010- Attention Inpatient and Outpatient Providers: As per MDCH policy bulletin MSA 10-46, MDCH has received approval for institutional crossover files starting December 9th, 2010 for inpatient and outpatient hospital claims. 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. The first two characters of the TCN will be 32. If the claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDCH showing all of the Medicare payment information. For more information regarding Institutional billing instructions and to access the crossover frequently asked questions (FAQ), providers may review the MDCH website at www.michigan.gov/medicaidproviders>> Billing and Reimbursement >> Medicare Crossover.

December 1, 2010- Attention: Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, Ventilator Dependent Care Units, Hospice, and Home Health Agencies: **Please see the following document regarding** Incorrect reporting of Other Insurance or Medicare on claims to Medicaid.

November 29, 2010- Attention Nursing Facility Providers: All Provider rates were updated in CHAMPS. Providers can submit adjustment claims for October 2010 dates of service to receive the difference.

November 23, 2010- Attention ALL Providers: **Claims Denied with REASON Code (CARC) 96 and Remark Code (RARC) N35.** As a reminder, if your claim status shows IN PROCESS in CHAMPS, **DO NOT** resubmit another claim. MDCH will be clearing these duplicate suspending claims off of the system on an ongoing basis, keeping only the most recently submitted claim that is suspending. You will see these claims on your Remittance Advice denied with Reason code 096/Remark Code N35. Do not resubmit those claims. If you get this denial, please do a search in claim inquiry on CHAMPS to find the additional claims.

November 20, 2010- Attention ALL Providers: We have identified an issue with claims sent on 11/08/2010. They appear to be randomly processing as a denied claim for "limits exceeded"; with no original pay date. These claims should be released by next pay cycle.

October 26, 2010- Attention ALL Providers: MDCH has identified a system issue with providers that have multiple specialties on file within CHAMPS. The issue has affected approximately 40,000 claims. These claims are incorrectly denying with Reason Code (CARC) 185 and Remark Code (RARC) N198 or the claims are not paying at the correct rate. MDCH is currently collecting the data necessary to reprocess the affected claims on behalf of providers.

October 21, 2010- Attention All Providers:Effective October 15, 2010 MDCH is reporting the following additional Managed Care Benefit Plans for Provoders in the CHAMPS eligibility screen and 270/271 transactions.

PIHP (Prepaid Psychiatric Inpatient Health Plan)
SA (Substance Abuse)
CMH (Community Mental Health)
CSHCS-MH (Children's Special Health Care Services, Medical Home)

Medicaid Managed Care (MA-MC) and Adult Benefit Waiver Managed Care (ABW-MC) continue to be provided on the eligibility screen and 270/271 transactions. Please ensure that you are utilizing the correct contact information associated with the appropriate benefit plan.

Please see the Benefit Plan Handout listed on our CHAMPS Resources page for additional definitions of these plans. http://www.michigan.gov/medicaidproviders >>CHAMPS. You can find the full plan

descriptions in the Medicaid Provider Manual http://www.michgan.gov/medicaidproviders >> Policy and Forms>> Medicaid Provider Manual.

September 14, 2010- Attention PDN Providers: **IMPORTANT NOTICE:** Effective October 1, 2010, the Michigan Department of Community Health (MDCH) will require Private Duty Nursing (PDN) providers to bill HCPCS codes S9123 and S9124 in one-hour increments as required in the 2010 HCPCS coding book. PDN services are prior authorized in hours. Therefore, when billing for services, the total number of hours billed - whether with S9123 and/or S9124 - must not exceed the total number authorized for that month. **Since whole hours of care are authorized, only those hours of care that entail a full hour of care may be billed.**

Please Note: Authorization letters for the month of October will authorize care in units but the quantity will reflect the number of hours approved for the month. **One unit = one hour.**

Refer to Bulletin MSA 10-35 for further information.

August 26, 2010- Attention All Providers: Quarterly Newborn recoveries were temporarily suspended as of July 2009 while MDCH implemented the new CHAMPS system. Beginning with Paycycle 33, MDCH will resume the quarterly takeback/recoveries for newborn beneficiary claims that were paid FFS where the newborn is now enrolled in a Medicaid HMO. The first recovery batch will be to catch up for claims paid prior to 3/31/2009, and MDCH will continue these takebacks in subsequent paycycles for legacy claims paid between 4/1/2009 - 6/30/2009 as well as claims paid between 7/1/2009 - 9/30/2009. After these 3 catchup batches, the next regular quarterly scheduled takeback/recovery will resume on a quarterly basis in October 2010. Please note, as with previous quarterly newborn takebacks, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remit Advice date.

August 11, 2010- Attention IPH Hospitals: MDCH recognizes that many hospitals have aging accounts currently suspending in CHAMPS that may affect their DSH and/or MIP reconciliations. IPH claims with dates of service prior to 1/1/2009 will be identified for priority processing over the next two weeks. If after the two weeks, hospitals still have additional outstanding aging accounts; hospitals may then contact ProviderSupport@michigan.gov with a listing of 25-50 TCNs for aging accounts that will be considered for priority processing. NOTE: Please only submit a list of the TCNs and as per HIPPA Privacy and Security guidelines, please do not send any Protected Health Information (PHI).

August 11, 2010- Attention Outpatient Providers: OPH claims with DOS on/after 7/1/2010 will no longer set the edit for "diagnosis code does not support procedure billed" when revenue code 450/452 is billed.
Claim Adjustment Reason Code: 11 - The diagnosis is inconsistent with the procedure.
Remittance Advice Remark Code: N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

August 05, 2010- Attention ALL Providers: The error that began on July 24th that restricted the allowed amount quantity to one (1) unit of service per claim line regardless of the number of units billed or normally allowed for certain procedure codes **has been resolved** as of August 4th. Providers should no longer experience this issue for TCNs with Julian dates greater than or equal to 10216 (yyddd). MDCH is currently collecting the data necessary to reprocess the affected claims on behalf of providers. Providers may also adjust the affected claims.

July 26, 2010- Attention Outpatient Providers: MDCH has identified a systems issue with the APC software which caused some Outpatient claims to pay $0 during the past week. Claims affected have been identified and will be mass adjusted by MDCH to correct the payment issue.

July 21, 2010- Attention ALL Providers: MDCH has identified an issue with a portion of the Outpatient legacy edit 743 Claims that were mass resurrected in CHAMPS in February. Some of these claims were not able to be successfully resurrected and will be denied with reason code 17/remark code N379 on the

next two Remittance Advices starting with 7/15/10. Beginning in early August, MDCH will be re-resurrecting these selected denied claims to process correctly through CHAMPS.

July 07, 2010- Attention Professional Providers: Claims which denied for Invalid Admission Date have been reprocessed and will appear on the next RA.

July 07, 2010- Attention Institutional Providers: An issue has been identified for Inpatient hospital claims whereby CHAMPS is not recognizing PACER numbers submitted using the Qualifier G4 (Loop 2300 Ref Segment). This issue is being worked on and until it is corrected, all Prior Authorization and/or PACER numbers should be submitted using the 2300 REF Qualifier G1 for Admission/Readmission/Elective IPH stays until further notice on all electronic claim submissions.

June 23, 2010- Attention All Providers: Due to planned upgrades to the FileNet system, Remittance Advices for Pay Cycle 25 (June 24, 2010) will not be available until Friday June 25,2010. Thank You.

June 10, 2010- Attention Institutional Providers:MDCH is currently working on an implementation plan for Institutional Crossover claims received directly from Medicare. We plan to have Institutional Crossovers in production by Fall 2010. The appropriate NPI for Medicaid adjudication must be reported on the initial claim sent to Medicare in order for the Crossover claim to adjudicate correctly in CHAMPS. MDCH will post additional information as it becomes available.

June 03, 2010- Attention All Providers: MDCH anticipates the next system update to occur on June 11th 2010. As a reminder, please do not re-submit claims if your claims are currently suspended in CHAMPS.

June 02, 2010- Attention All Providers: During the first week of April 2010, MDCH identified an issue with the way CHAMPS calculates a beneficiary's age during the adjudication of some claims. This issue was corrected, and while it did not impact the actual editing or pricing of the claims, it still required that certain claims with incorrect ages be reprocessed so that reporting and statistical claims data is accurate. MDCH has reprocessed the impacted claims to correct the age calculation and these adjusted claims should appear on your next RA.

May 26, 2010- Attention All Providers: MDCH would like to remind Providers when billing secondary claims to Medicaid to report the Claim Adjustment Reason Code(s) (CARC) reported by the primary payer. If the primary payer typically covers the service, however, indicates the service is non-covered (CARC 96), claim notes indicating why the service was not covered by the primary payer are recommended.

May 24, 2010 MDCH is currently processing newborn applications after 4/18/2010 into Health Plans.

May 24, 2010- MDCH is currently processing the Hospice Membership Notice (DCH1074) Forms received as of 05/03/2010.

May 24, 2010- Attention All Providers: Per MDCH Policy, providers that are submitting secondary claims on paper must submit the Allowed Amount as the Submitted Charges on the paper claim form. If the Submitted Charges are different than the Allowed Amount from the Explanation of Benefits (EOB), MDCH will reject the claims. Please refer to the Provider Manual, Billing & Reimbursement for Professional chapter, Section 3 Claim Completion instructions, for additional information. Due to the number of secondary paper claims and the processing time, MDCH encourages all providers to submit claims electronically. If you do not have a Billing Agent, MDCH offers the free Direct Data Entry (DDE) option directly in CHAMPS.

May 20, 2010- Attention All Providers: MDCH has identified over 56,000 duplicate suspending claims in CHAMPS since go live. These duplicates are a result of multiple provider submissions of the same

claim. In the next week, MDCH will be clearing these duplicate suspending claims off of the system, keeping only the most recently submitted claim that is suspending. You will see these claims on your next RA denied with Reason code 096/Remark Code N35.

Please do not resubmit these denied duplicate suspending claims. As a reminder, if your claim is currently suspending in CHAMPS, please do not resubmit another claim as this will increase our backlog and the time it takes to get to resolving your initial claim.

May 19, 2010- Attention All Providers: MDCH urges Providers that send secondary claims on paper to consider submitting those claims using the CHAMPS Direct-Data-Entry (DDE) Claim Submission or through a Billing Agent using the 837 electronic claim format. Use of the DDE and/or Billing Agent offers several advantages including:

Ø Eliminates the need to attach the Explanation of Benefits (EOB). DDE and the 837 allow other insurance payments to be reported using Claim Adjustment Reason Codes (CARC). In the CHAMPS DDE screens these codes are referred to as "Reason Codes." The CARC Codes can be found at www.wpc-edi.com/ .

Ø Claims that are submitted DDE will appear in CHAMPS within approximately 15 minutes

Ø Claims received electronically on the 837 appear in CHAMPS the following day.

May 17, 2010- Attention All Providers: MDCH is currently developing a training webcast focused on Medicaid Trading Partners; specifically Medicaid Billing Agents or provider staff who transmit HIPAA 837 electronic claims directly to MDCH via the DEG or CHAMPS screens and who receive and translate HIPAA 835 electronic remittance advice and 277U electronic claims status (pended claims) files on behalf of Michigan Medicaid providers. The webinar is expected to be released in mid-to-late June and will be available on the CHAMPS informational website.

Billing Agents are encouraged to submit questions and topics that they would like MDCH to cover during the training. All questions/comments must be submitted to mailto:AutomatedBilling@michigan.gov by May 21st. The subject of the email must be "Webcast Questions/Comments - [Your Subject Here]".

A listserv message will be sent when the webcast has been released on the CHAMPS informational website.

May 13, 2010- Attention All Providers: In the event you receive a denial as the result of a Champs related defect, please resubmit your claim. When the claim exceeds the one year billing limitation, please include the TCN of the denied claim in the claim notes area.

May 13, 2010- Attention All Providers: The resubmission of "INPROCESS" claims is causing additional backlog for the claims processing unit. Claims with a status of "INPROCESS" in CHAMPS are pending for review. Providers should not rebill claims that are in this status as it will also pend or create an new "INPROCESS" claim.

May 12, 2010- Attention: Family Planning Clinics, FQHCs, Outpatient Hospitals, LHDs, Medical Suppliers, MH/SA, Nursing Facilities, Practitioners, RHC and THC providers: The implementation of the CHAMPS system allows MDCH to adjudicate claims compliant with the federal mandate requiring the National Drug Codes (NDC) for physician-administered drugs administered in a physician office, clinic, beneficiary home, local health department or outpatient hospital setting. MDCH policy was published effective for dates of service on or after July 15, 2007 for professional claims (MSA 07-33) and on or after July 1, 2008 for institutional outpatient claims (MSA 08-02). This information is available in the on-line MDCH Provider Manual at www.michigan.gov/medicaidproviders . In the CHAMPS system, if you bill a

HCPCS code representing a physician-administered drug and your claim has one of the following conditions, then the service line will deny: service lines with an invalid HCPCS and NDC combination reported, service lines with an invalid or missing NDC at the service line and service lines with non-rebateable NDCs reported. The implementation of these edits has been phased in and will be fully operational by June 2010.

A denied service line on a claim will have these reason and remark codes:

Adjustment Reason Code	Remittance Remark Code
16 - Claim/service lacks information which is needed for adjudication	M119 - Missing/incomplete/invalid National Drug Code
181 - Procedure code was invalid on the date of service	
211 - National Drug Codes (NDC) not eligible for rebate, are not covered	

May 10, 2010- Attention Outpatient Providers: MDCH has begun reprocessing all Outpatient claims paid by CHAMPS to date. This reprocessing is to correct several system and OPH pricing issues that have now been resolved. PLEASE NOTE: MDCH will only be reprocessing those paid claims which result in a payment/processing correction - not every OPH claim that has been adjudicated by CHAMPS. Starting this week, MDCH has reprocessed all September and October pay cycles for these OPH claims and will begin working to adjust November/December claims with payment/processing differences in the upcoming weeks. Please check the CHAMPS Provider updates for more information.

May 5, 2010- Attention All Providers: Please be advised that the Third Party Liability will resume the Pending Claim Adjustment Report process in the near future. This will include both Medicare and Commercial claims.

April 28, 2010- Attention Providers Submitting Paper Claims: Paper claims are inherently less reliable than electronic claims because paper claims require manual human intervention to adjudicate the claims. The adjudication steps for electronic claims are all automated, uniform, and therefore much more predictable . MDCH encourages all providers to either submit electronic claims or utilize the CHAMPS Direct Data Entry Claim Submission in order to avoid the unexpected and unreliable outcomes associated with paper claim submissions.

April 28, 2010- Attention Nursing Facility Providers: A beneficiary who has a patient pay amount cannot legally be charged more than the Medicaid rate for a short stay in a facility. For example, if a beneficiary is in a long term care facility for two days in a month, the provider must collect no more than the Medicaid rate for two days from the patient pay amount (even if the patient pay amount is great enough to cover the higher private pay rate). The balance or unused portion of the patient pay amount must be returned to the beneficiary or his family.

April 14, 2010- Attention CMH Providers: See Letter regarding: CHAMPS SED Waiver; Children's Waiver Program (CPW) Payment Implications

April 13, 2010- Attention Outpatient Providers: The March CHAMPS system update resulted in a new issue with some Outpatient claims. If a provider bills zero dollars on a line of an outpatient claim, the line will now pay zero instead of using the logic to take into account the dollars from the other lines. MDCH is working on resolving this error as soon as possible. Please continue to check this website for updates.

April 13, 2010- Attention Health Plan Network Providers: Providers who are both Medicaid enrolled and a health plan network provider can see both their claims AND encounters in CHAMPS. An encounter can be differentiated from a claim on the list page by looking at the Transaction Control Number (TCN). The first two characters of an encounter TCN will always begin with 33. If the provider clicks on the TCN

hyperlink, the encounter will show a "Source" of HIPAA ENCOUNTER in the upper right hand corner. On the list page any Claim Status value of "Accept “or "Reject" indicates encounter (claims will never have these statuses).

April 1, 2010- Attention Institutional Providers: MDCH is now able to create the FD-622 report, dating back to the first pay cycle paid from CHAMPS (pay cycle 39). This report will be mailed to the correspondence address, on file within the Provider Enrollment application. MDCH is currently mailing the Outpatient and Inpatient reports separately until pay cycle 43 (October). Please be aware that the initial FD-622 mailed for Inpatient providers was identified as Payroll 11, 3/18/2010 and contained payroll 11 information. This mailing sequence has been corrected and the report will now be mailed in date order (oldest to most recent).
Beginning with paycycle 44 both the Outpatient and Inpatient reports will be sent in a single mailing. The FD-622 report for Long Term Care Facilities will be mailed in the near future. Please continue to check the website for updates.

April 1, 2010- Attention Hospice Providers: Recently hospice providers received a letter informing them of their seven-digit Medicaid Provider ID number in CHAMPS. This number is necessary when completing the Hospice Membership Notice, DCH-1074. Do not resend DCH-1074 forms to Enrollment Services Section (ESS) for the sole purpose of updating them with the new Provider ID number. This is not necessary and places an undue burden on the ESS causing a backlog of forms further delaying hospice enrollments.

March 30, 2010- Attention Nursing Facility, Private Duty Nursing, Home Health, Hospice Providers: MDCH would like to remind providers to verify the diagnosis codes being billed are valid ICD-9-CM and that the beneficiary's age is valid for the diagnosis code being billed.

March 9, 2010- Attention Nursing Facility Providers: After the implementation of CHAMPS, the systems edit between the Medicaid Nursing Facility Level of Care Determination (LOCD) and the CHAMPS payment system was disabled. The Michigan Department of Community Health has addressed the issues between the systems and is now ready to reactivate this edit. Please be advised that beginning April 1, 2010, the CHAMPS system will reinitiate editing to ensure that the LOCD is conducted timely and in accordance with Medicaid policy, which can be found in the Medicaid Provider Manual, Nursing Facility Chapter, Section 4.1D.

March 4, 2010- MDCH is currently completing the gap analysis and planning for the HIPAA 5010 and ICD-10 project. MDCH expects to follow the Industry timeline and is targeting for a January 1, 2011 external trading partner testing date. The HIPAA 5010 mandate for Production transactions is January 1, 2012. MDCH will provide additional information regarding testing after the analysis has been completed. Please review the MDCH website for additional updates.

March 2, 2010- Attention All Providers: MDCH would like to remind Providers that only approved claims can be adjusted. A claim is considered approved if at least ONE line paid, and paying $0.00 is considered a paid claim. Claims that have previously paid should not be resubmitted as a new claim in the system, but rather submitted as an adjustment if a change is necessary or reprocessing is in order. Claims will deny for duplicate if incorrectly submitted as a new claim rather than an adjustment claim.

March 2, 2010- Attention Home Health Providers:The Medicaid Payments Division has been seeing a large number of Home Health Agency claims for Procedure Code G0154 (Nurse Visit), that appear to be exact duplicates of a previous claim. Beginning March 1, 2010, these duplicate claims will reject with the appropriate Reason and Remark code(s). Note: If billing for more than one nurse visit on the same date of service you must bill each visit on an individual claim line, on the same claim. Duplicate claims for services on the same date of service will be rejected.

February 19, 2010- Attention Nursing Facility Providers: A Reminder to Nursing Facility providers to

verify the beneficiary's age is valid for the diagnosis code billed. Claims will pend if the age of the beneficiary is not valid for the diagnosis code being billed.

February 19, 2010- Attention All Providers:Please be advised that the Third Party Liability Division has begun processing the 'Pending Claim Adjustment' reports that were sent to Providers in July, August, September, October and November 2009 as well as any outstanding claim adjustment letters. The claims will be adjusted over a period of several weeks to lessen the impact on the Providers. Please refer to the 'Pending Claim Adjustment' reports or the claim adjustment letters for contact information should you have any questions or concerns.

February 19, 2010- Claims submitted via paper will suspend for processing. MDCH recommends providers use the CHAMPS Direct Data Entry (DDE) tool for claims currently being submitted via the paper claim form. Submission through the DDE system will result in a faster turnaround time. Providers can contact the CHAMPS Helpline at 888-643-2408 for assistance on how to use this tool in CHAMPS.

February 19, 2010- Attention Dental Providers: MDCH continues to recieve many dental claims in which the Rendering/Servicing Provider NPI is being incorrectly reported as the Billing Provider. All dental claims must report a Billing Provider (Type 2 NPI) in F.L. 49 and a Rendering/Servicing (Type 1 NPI) in F.L. 54. Claims submitted incorrectly will be denied.

February 19, 2010- Attention Nursing Facility Providers: MDCH is current in processing the Medicare Advantage (Medicare Part C) Nursing Home claims.

February 17, 2010- Attention All Providers: CHAMPS will be unavailable March 25th-30th. During this time enrolled providers may contact the CHAMPS Helpline at 888-643-2408 to verify member eligibility.

February 9, 2010- Attention Hospital, Nursing Facility Billers : MDCH would like to remind providers that Admission Source is a required field. Claims missing the Admission Source will deny.

February 9, 2010- Attention Clinic and Special Programs (i.e. FQHC, LHD, MIHP, FP, etc.) Issues Resolved: Agencies with a single NPI for multiple clinic and/or special program specialties can bill for all services including MIHP. Agencies can bill for blood-lead related services and hearing and vision screening for children 3-6 years old whether they are enrolled in fee-for-service Medicaid or a Medicaid health plan*. Agencies can also bill for MIHP services provided in the home and receive the appropriate rate*. Billing NPIs that experienced denials because their enrollments were changed from Group to "FAO" enrollments have been able to bill since January 22nd. Some of the rendering providers from the group enrollments were not re-associated to the new FAO enrollments so some denials occurred between January 22nd and February 2nd for that reason. MSA's Provider enrollment staff have since added the missing associations but providers are encouraged to review both their rendering and billing NPI enrollments to ensure their accuracy.

Now that these issues have all been resolved, we recommend that each agency begin billing these services slowly with a small batch first and then larger batches after those claims. If submitted through the data exchange gateway by 5pm (the way that most billing agents like Netwerkes submit their claims) the claims will adjudicate overnight. If submitted by batch upload by 5pm the claims will also adjudicate overnight. If submitted by Direct-Data-Entry via the CHAMPS screens the claims are adjudicated within 15 minutes. Pay-cycle cutoffs are generally on Tuesday at 5pm for DEG and batch upload and Wednesday at 4pm for Direct-Data-Entry.

February 2, 2010- Attention Nursing Facility Providers: MDCH is automatically suspending Medicare Advantage nursing home claims for manual review. MDCH understands this is a timely process, but it is required to ensure claims are paid correctly. MDCH asks for your patience and assures you that every effort is being made to process effectively and efficiently.

January 29, 2010- MDCH Paycycle Calendar

January 14, 2010 - Attention Outpatient Hospitals/Billers: MDCH has completed the testing and implementation of the October APC software and pricing updates in CHAMPS. Providers can now rebill for any claims rejecting with DOS on/after 10/1/2009 with the H1N1 procedure codes and/or claims rejecting with October1st new ICD-9-CM diagnosis codes. MDCH will be reprocessing all CHAMPS adjudicated OPH claims mid to late February to resolve numerous issues with OPH editing and pricing since CHAMPS go live. Please continue to check the CHAMPS website for upcoming information and updates.