



Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

Skilled Nursing Facility

March 21, 2017

“Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time.”

-Provider Relations

Agenda

- Level of Care Determination (LOCD) Tool
- Back Log
 - LOCD Tips
- CHAMPS
 - System Updates
- Policy & L Letters Updates
- Medicaid Health Plan Disenrollment
- Top 5 Rejection & Suspended Reason Codes
 - Billing Tips

Level of Care Determination (LOCD) Tool

Back Log

LOCD Tips

MDHHS MSA-2565-C Process

Back Log

- October 2016
 - Provider Support email processing April-May 2016 received date
- March 2017
 - Provider Support email processing February 2017 received date

LOCD Tips

- [How to filter Level of Care Determination \(LOCD\) within CHAMPS](#)
- [Locating Provider ID within CHAMPS](#)
- [Inactive LOCD Completed waiting for LOC/MA](#)
- [LOCD status inquiry](#)

MDHHS MSA-2565-C Process

- Central Scan
 - Fax (517) 346-9888
- MSA2565@michigan.gov
 - Must contain correct NPI and Provider ID number
 - Field 12A and 12B
 - Admit Date
 - Discharge Date (if applicable)
 - Must use current form [MSA 2565-C](#)
 - If the member was in and out of the facility, each admission would require a new MSA-2565-C.

CHAMPS

System Updates

CHAMPS Upcoming Updates

System Updates

- Multiple LOCD records active, waiting LOC/MA
 - (FIX) Logic to select based the LOCD record on earliest created on date
- LOCD record remaining active when transferred to new facility
 - (FIX) Logic will assign an end date based on LOC match
- Therapy services can be billed with room and board for Ventilator Dependent Care Unit (VDCU) services.

March 25, 2017 Release

CHAMPS Upcoming Updates

- Active LOCD records have default 10-31-2017 end date
 - June 2017 will update to 12-31-2999
- Duplicate LOCD's will be changed to inactive status

Policy & L Letter Updates

[MSA 16-37 – Timely Filing](#)

[L 16-16 – Change of Ownership](#)

[L 16-66 – Accepting/Refunding Monies](#)

[L16-42 – MI Health Link Enrollment](#)

MSA 16-37 Timely Filing

- Claims are due within 12 months from the date of service (DOS). Each claim received by MDHHS receives a TCN that indicates the date the claim was entered into CHAMPS. The TCN is used when determining active review for a claim. Claims over one year old will only be considered if the reason for filing the claim late is due to one of the policy exceptions and the exception is properly documented.
 - Claim replacements must be filed within 12 months from the date of service.
 - Claim adjustments require comments/notes.

MSA 16-37 Timely Filing (cont.)

- All claims for services rendered prior to 1-1-2017 and have been kept active according to prior timely filing policy, will be allowed to be considered if kept active every 120 days from the latest rejection. In all cases, claims must be submitted no later than 12-31-2017.
- [Provider Tips Timely Filing Effective 1-1-2017](#)

L 16-16 Change of Ownership

- Revised Medicaid Enrollment Checklist for new or currently enrolled facilities undergoing Change of Ownership (CHOW).
- [The revised Medicaid Enrollment Checklist :](#)
 - Notify the local MDHHS office if there is change in the facility's NPI/Medicaid Provider ID number.
 - Notification must be made via a revised MSA-2565-C to the local office.
 - Notification applies to a facility enrolling in the Medicaid Program or an enrolled facility that has a change of ownership where the NPI/Medicaid Provider ID number changes.
 - *Note: When completing the MSA-2565-C the NPI field must also contain the effective date of the new NPI number.*

L 16-66 Accepting/Refunding Monies

- Clarification to certain conditions in which a resident pays the nursing facility and the Medicaid application is pending.
 - Retroactive Medicaid eligibility is granted if there are unpaid medical expenses.
 - Resident has made partial payments to the nursing facility and the resident has retroactive eligibility for the same period of time.
 - Nursing facilities must report any resident payments for nursing facility services to the eligibility case worker.
 - Nursing facilities must report resident payments using Value Code 22 with claim notes
- A pre-payment for nursing facility services not yet received is considered a countable asset and could affect eligibility determination.

L16-42 MI Health Link Enrollment

- Effective July 1, 2016 MDHHS implemented a new process for beneficiary enrollment in the MI Health Link program.
- Deeming Eligibility Period
 - Even though it appears as if member has lost full Medicaid eligibility in CHAMPS these individuals will remain enrolled in the MI Health Link Plan during the deeming period. This period will last up to three months after an individual loses full Medicaid eligibility, or until the individual regains full Medicaid eligibility, whichever is sooner.

L 16-42 MI Health Link Enrollment (cont.)

- ICO's are required to provide MI Health Link covered Medicare and Medicaid services to individuals during the deeming period.
 - Providers can see a deeming indicator in members eligibility record for single date of service.
 - Providers must bill the ICO for services.
 - When eligibility is regained the ICO-MC benefit plan will be reinstated for the applicable months.
 - Deeming indicator will show an end date.
- [Example of deeming indicator in member eligibility record](#)

Medicaid Health Plan Disenrollment

Traditional

Administrative Error

Health Plan Contacts/Disenrollment

Traditional

- The Medicaid Health Plan (MHP) is responsible for restorative or rehabilitative care in a nursing facility up to 45 days. If the services will exceed this coverage (45 days) the health plan may initiate the disenrollment by submitting the MSA-2007. The nursing facility may bill Medicaid after the disenrollment is processed.

Administrative Error

- Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. However, due to administrative error, a beneficiary may occasionally be enrolled into a MHP.
- Disenrollment due to administrative error may be requested by the nursing facility or the MHP by submitting the [DCH-1185](#).
- The disenrollment request must be submitted to MDHHS within six months of the administrative error occurrence. Requests that exceed six months from the date of occurrence will be retroactive to six months from receipt of the DCH-1185.

Health Plan Contacts

- McLaren Health Plan

- Andrea DeVellis 810-733-9631
- Midge Collie 810-733-9648
- Colette Koliboski 517-913-2612
- Michelle Simmons 810-733-9542

- Meridian Health Plan

- Debra Roskopp 313-324-3700

- Molina Healthcare

- Paula Jaworowski 866-499-6828 ext. 155836
- Leslie Pascoe 866-499-6828 ext.155433

Health Plan Contacts (cont.)

- Priority Health Choice
 - Paige Evenhouse 616-355-3259
- Total Healthcare
 - Christine Dozier 313-871-7890
 - Virginia Long 313-871-6405
 - Lisa Goodson 313-871-6584
- United Healthcare
 - Carrie Klug-Ackerman 248-331-4403
- Upper Peninsula Health
 - Mary Maki 906-255-3583

Health Plan Disenrollment Contacts

- Blue Cross Complete
 - Deronda Honig 843-414-2684
 - Jennifer Blanton 843-414-8374
- AETNA Better Health of Michigan
 - Michelle Cobb 313-324-7544
 - Laura Smith 313-324-7542
- HAP Midwest Health Plan
 - Deborah Coney 313-586-6079
- Harbor Health Plan
 - Kinga Rudnicki 313-578-3747
- **Access to Care Concerns:**
 - Email Mozell McKellar directly Mckellarm@Michigan.gov
 - Direct line 517-284-1156

Top 5 Rejection & Suspended Codes

Billing Tips

Top 5 Rejection Codes

- B7 Provider not certified/eligible to be paid for this service/procedure on this date of service
- 96/N216 Non Covered Charges/We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit
- 16/M53 Claim/service lacks information which is needed for adjudication, missing/incomplete/invalid days or units of service
- 16/M49 Claim/service lacks information which is needed for adjudication, Missing incomplete/invalid value codes
- 96/N35 Non Covered charges Program integrity/utilization review decision

Top 5 Suspended Codes

- 29 Timely filing has expired
- 16/MA32 Claim/service lacks information Missing incomplete invalid number of covered days
- 16/N345 Claim/service lack information date range not valid with units submitted
- 22/N598 This care may be covered by another payer per COB. Health care policy coverage is primary

Billing Tips

- When reporting Medicare, Nursing Facilities must bill as outlined below
- **Covered Days**
 - Covered days must be reported by using Value Code 80
 - Covered days are the days in which Medicare approves payment for the beneficiary's skilled care. Covered days must be reported when the primary insurance makes a payment
 - Coinsurance days must be reported with Value Code 82
- **Non-Covered Days**
 - Non-covered days must be reported using Value Code 81
 - Non-covered days are the days not covered by Medicare due to Medicare being exhausted or the beneficiary no longer requiring skilled care.

Billing Tips (cont.)

- When Medicare non-covered days are reported because Medicare benefits are exhausted, facilities must report Occurrence Code A3 and the date they were exhausted, along with the CARC 96 (non-covered charges) or 119 (Benefit Maximum for the time period has been reached.)
- When Medicare non-covered days are reported because Medicare active care ended, facilities must report Occurrence Code 22 and the corresponding date Medicare active care ended, along with the CARC 96 or 119.

Billing Tips (cont.)

- **Coinsurance Days**

- Medicare coinsurance days must be reported using Value Code 82.
- Coinsurance days are the days in which the primary payer applies a portion of the approved amount to coinsurance.
- When reporting Value Code 82, Occurrence Span Code 70 and corresponding from/through dates (at least three-day inpatient hospital stay which qualifies the resident for Medicare payment of SNF Service) must also be reported.

- **Prior Stay**

- If a SNF or nursing facility stay ended within 60 days of the SNF admission, Occurrence Span Code 78 and the from/through dates must be reported along with the Occurrence Span Code 70 and the from/through dates.

Provider Resources

- **MDHHS website:** www.michigan.gov/medicaidproviders
- **We continue to update our Provider Resources, just click on the links below:**
 - [Listserv Instructions](#)
 - [Medicaid Alerts and Biller “B” Aware](#)
 - [Quick Reference Guides](#)
 - [Update Other Insurance NOW!](#)
 - [Medicaid Provider Training Sessions](#)
- **Provider Support:**
 - ProviderSupport@michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program