MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: HCFA 1500/837 Professional Providers – MSA 03-15
(See Manual Maintenance for Bulletin Number Distribution)

Issued: August 15, 2003

Subject: Chapter IV (Billing and Reimbursement for Health Care Professionals)

Effective: October 1, 2003

Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Program, Maternity Outpatient Medical Services (MOMS) Program

This bulletin transmits the revised Chapter IV (Billing and Reimbursement for Health Care Professionals). As a part of the chapter revision process, previously issued policy bulletins have been incorporated. Rewording and clarification of existing policy and policy changes have been incorporated which reflect issues raised and clarifications requested by the provider community and within the Michigan Department of Community Health (MDCH).

The attached Chapter IV is effective for dates of service on or after 10/01/2003. The revisions to this chapter allow for HIPAA compliance and further refine the uniform billing project goal of consistency of billing requirements between Medicaid and other payers.

In reviewing this chapter, please note the following:

- The Third Party Billing section (formerly section 6) has been eliminated. Billing related issues have been moved into the Special Billing section. Other third party issues have been moved to the Coordination of Benefits Chapter of this manual.

- The Help section (formerly section 11) has been eliminated. This information has been moved to the Directory Appendix of this manual.

- Children's Waiver billing information and modifiers have been added to the Special Billing and the Modifiers sections of this chapter.

- Modifiers which affect processing the claim or payment of the claim are updated for HIPAA compliance.

- Recoding from national procedure codes submitted to Medicare and other payers to not otherwise classified (NOC) codes when billing Medicaid is limited.

- Clarification of information required on the claim when billing for items that have an NDC code assigned.

- Submission of void/cancel claims is incorporated.

The Department is in the process of redesigning it's provider manuals with the goal of producing a single all provider manual. As this process takes place, information may be shifted to different sections or chapters.

Manual Maintenance

Bulletin distribution and numbering by provider manual:

Ambulance 03-04, Chiropractic 03-01, Community Mental Health Services Program 03-03, Family Planning Clinics 03-03, Federally Qualified Health Centers and Indian Health Centers 03-01, Hearing Aid Dealers 03-03, Hearing and Speech Centers 03-03, Laboratory 03-02, Maternal and Infant Support Services 03-03, Medicaid Health Plans 03-07, Medical Supplier 03-03, Practitioner 03-05, Rural Health Clinic 03-01, Vision 03-01.

Replace the Medicaid Manual Chapter IV issued April 1, 2002 (MSA 02-08) **for dates of service on or after 10/01/2003. Continue to use MSA 02-08 for dates of service prior to 10/01/2003.**

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration

Section 1 – General Information

Section 2 - How to File Claims

Section 3 - Claim Completion

Section 4 - Replacement and Void/Cancel Claims

Section 5 - Changes in Eligibility/Enrollment (FFS/MHP/CSHCS)

Section 6 - Special Billing

Section 7 - Modifiers

Section 8 - Remittance Advice

Section 9 - Julian Calendar

INTRODUCTION

This chapter contains the information needed to submit professional claims to the Michigan Department of Community Health (MDCH) for Medicaid, Children's Special Health Care Services (CSHCS), and the State Medical Program (SMP). It also contains information about how we process claims and how we notify you of our actions.

The following providers must use the ANSI X12N 837 4010 A1 professional format when submitting electronic claims and the HCFA 1500 claim form for paper claims:

Ambulance
Certified Nurse Midwives
Certified Nurse Practitioners
Certified Registered Nurse Anesthetists
Chiropractors
Community Mental Health Services Programs/ Prepaid Inpatient Hospital Plans
Family Planning Clinic
Federally Qualified Health Centers
Hearing Aid Dealers
Hearing and Speech Centers
Independent Labs
Indian Health Centers
Maternal and Infant Support Services
Medical Clinics
Medical Suppliers
Optical Companies
Optometrists
Oral Surgeons
Orthotists and Prosthetists
Physical Therapists
Physicians, MD & DO
Podiatrists
Private Duty Nurses (Individually Enrolled)
Rural Health Clinics
School Based Services
Shoe Stores

CLAIMS PROCESSING SYSTEM

All claims submitted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through the CP system are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and combination of service edits. Electronic claims filed by Wednesday may be processed as early as the next weekly cycle.

We encourage claims to be sent electronically by file transfer or through the data exchange gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated.

REMITTANCE ADVICE

Once claims have been submitted and processed through the CP System, a paper remittance advice (RA) will be sent to each provider with adjudicated or pended claims. An electronic health care claim payment/advice (ANSI X12N 835 4010A1) will be sent to the designated primary service bureau for providers opting for an electronic RA. See the Remittance Advice section of this chapter for additional information about both the paper and electronic RA.

ADDITIONAL RESOURCE MATERIAL

Additional materials needed to bill include:

Provider Manuals: These manuals include program policy and special billing information. Provider manuals and other program publications are available at a nominal cost from MDCH. (Refer to the Directory Appendix for additional information.)

Bulletins: These intermittent publications supplement the provider manual. The bulletins are automatically mailed to subscribers of the affected provider manuals. Recent bulletins can be found on the MDCH website.

Numbered Letters: General program information or announcements are transmitted to providers via numbered letter. These can be found on the MDCH website.

Remittance Advice Messages: RA messages are sent to specific provider groups with the remittance advices and give information about policy and payment issues that affect the way services are billed and paid.

Medicaid Databases: These list procedure codes, descriptions, fee screens, and other pertinent coverage, documentation, and billing indicators. They are available on the MDCH website.

Note: Find the MDCH website at www.michigan.gov/mdch, Click on Providers and proceed to Information for Medicaid providers.

CPT and HCPCS Coding Manuals: These manuals are published annually listing national CPT and HCPCS codes. The publications are available from many sources, such as the AMA Press at 1-800-621-8335 or Medicode at 1-800-999-4600.

International Classification of Diseases, Clinical Modification (ICD-9-CM): Diagnosis codes are required on your claims using the conventions detailed in this publication. This publication is updated annually. It may be requested from Medicode at 1-800-999-4600 or the AMA Press at 1-800-621-8335. Additional resource information is available in the Directory Appendix of this manual.

HOW TO FILE CLAIMS

You may submit your claims **electronically** or on **paper.** Electronic claim submission is the method preferred by MDCH.

ELECTRONIC CLAIMS

Electronic claims submitted and accepted are entered directly into the Claims Processing System resulting in faster payments, and fewer pends and rejects. Claims can be submitted by file transfer or through the data exchange gateway. The electronic claim format is the ANSI X12N 837 4010A1 professional. Providers must use this version.

For information on submission of electronic claims, go to the MDCH website. The MDCH Electronic Billing Manual and other resources such as the companion guides are located there. Information will be updated on the website as version changes occur at the national level and the department adopts those changes.

See the Directory Appendix for website information.

AUTHORIZED ELECTRONIC BILLING AGENTS

Any entity (service bureau or individual provider) that wishes to submit claims electronically to the MDCH must be an authorized electronic billing agent. The authorization process is easy:

1. Contact the MDCH Automated Billing Unit for an application packet. (See information below.)
2. Complete and submit the forms in the application packet (an application and a participation agreement).
3. Receive an identification number.
4. Format and submit test files.
5. Once test files are approved, receive full authorization from MDCH to bill electronically.

Once you are an authorized electronic billing agent, any provider (including yourself) who wants you to submit claims on their behalf must complete and submit the Medicaid Billing Agent Authorization (DCH-1343) form to the MDCH. This form certifies that all services the provider has rendered are in compliance with Medicaid's guidelines. MDCH will notify each provider when it has been processed. After notification, you can begin billing electronically for yourself or other providers that have been approved to use you as their billing agent. More than one billing agent per provider will be authorized to submit the provider's claims on Electronic File. Only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ANSI X12N 835 4010A1. Refer to the Remittance Advice section of this chapter for additional information. Authorizations remain in effect unless otherwise indicated in writing by the provider.

The electronic billing agent authorization process, specifications for test files, specific information about electronic billing and the transaction set for professional claims can be found on the MDCH website. Test claims will not be processed for payment. Any live claims for services rendered must be billed on paper until the authorization process is complete.

Any individual provider can submit claims electronically as long as the authorization process is completed; however, many providers find it easier to use an existing authorized billing agent to submit claims to the program. The billing agent takes claim information gathered from all of its clients and formats it to HIPAA compliant MDCH standards. The data are then sent to the MDCH for processing. Whether you submit electronic claims directly or through another authorized billing agent, a paper remittance advice (RA), which reflects your individual claims will be generated. Your billing agent will receive this document which contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents:

E-mail: AutomatedBilling@michigan.gov

Or write to: Michigan Department of Community Health
Medicaid EDI Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

ELECTRONIC CLAIMS WITH ATTACHMENTS

If comments or additional information is required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report or other paper attachment is required and an electronic claim is submitted, refer to the electronic billing manual for instructions for submitting paper attachments for electronic claims.

PAPER CLAIMS

When submitting paper claim forms, use the HCFA 1500 form. It must be a red ink form with the numbers (12-90) RRB-1500 in the lower right corner. The version with the four black alignment bars in the upper left corner is the preferred version. Paper claims are scanned by our Optical Character Reader (OCR).

Claims may be prepared on a typewriter or on a computer. We will not accept handwritten claims. The claims are optically scanned and converted to computer data before being processed. Print problems may cause misreads by our scanning equipment thus delaying processing of your claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn out ribbons.

Note: Dot matrix printers result in frequent misreads by the OCR.

Questions and problems with the compatibility of your equipment with our scanners should be directed to the OCR Coordinator at:

Michigan Department of Community Health
Attn: OCR Coordinator - Operations
3423 N. MLK Jr. Blvd.
Lansing, MI 48909

OR

E-Mail Address: OCRCoordinator@michigan.gov

GUIDELINES TO COMPLETE PAPER CLAIM FORMS

The following guidelines are to be used in the preparation of paper claims to assure that information contained on the claims is correctly read by the scanning equipment. Failure to adhere to the guidelines may result in processing/payment delays or claims being returned unprocessed.

- Dates must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 10012003). Be sure the dates are within the appropriate boxes on the form.
- Use only black ink. Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- Upper case alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12 point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. DO NOT squeeze comments below the service line.
- Do not send us damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correcting typewriters.
- If you make a mistake, start over and prepare a "clean" claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, with no folding, in 9" x 12" or larger envelopes.
- Put your return address on the envelope.
- Separate the claim form from the carbon.

- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut the edges of the forms.
- Keep the file copy for your records.
- Mail HCFA 1500 claim forms separately from any other form type.

PROVIDING ATTACHMENTS WITH PAPER CLAIM FORMS

When a claim attachment is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID Number. Attachments must be 8 ½ " x 11", on white paper, and one-sided. Do not submit two-sided material. Multiple claims cannot be submitted with one attachment. Do not staple or paperclip the documentation to the claim form.

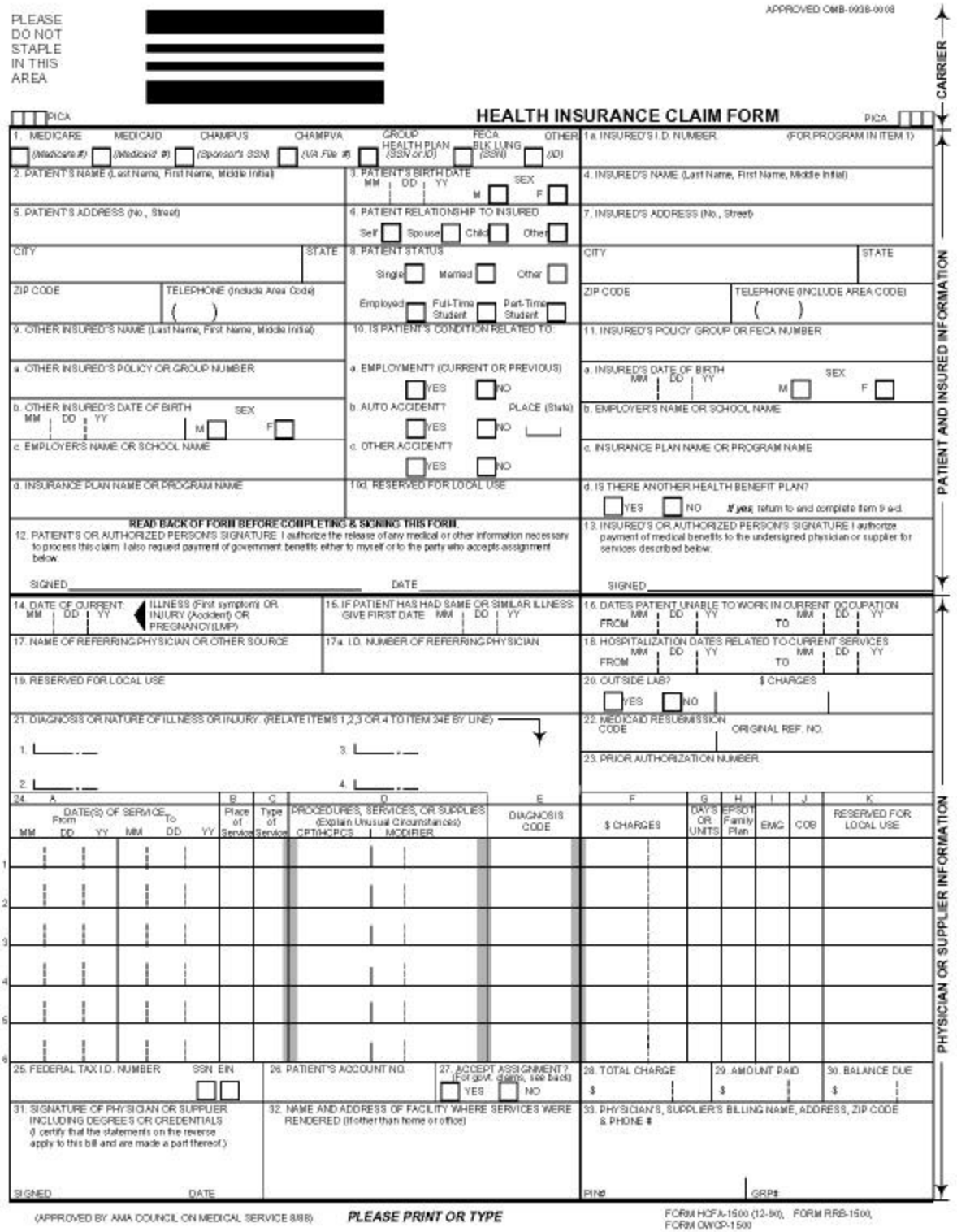
Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required. Unnecessary attachments will delay the processing of your claim.

MAILING PAPER CLAIM FORMS

All paper claim forms and claim forms with attachments must be mailed to:

Michigan Department of Community Health
P.O. Box 30043
Lansing, MI 48909-7543

HCFA 1500 CLAIM FORM (front)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

HCFA 1500 CLAIM FORM (back)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

The following claim completion instructions apply to all claims submitted to the MDCH by providers. Providers who submit claims to a Medicaid Health Plan (MHP) must contact that plan directly to determine if there are any different or additional requirements for claim completion.

HCFA 1500 CLAIM COMPLETION INSTRUCTIONS

1. **Insurance:** Show the type of health insurance coverage applicable to this claim by checking the appropriate box.

1a. **Insured's I.D. Number:** Enter the patient's eight-digit Medicaid identification number.

2. **Patient's Name:** Enter the patient's last name, first name, and middle initial, if any.

3. **Patient's Birth Date and Sex:** Enter the patient's eight-digit birth date (MMDDCCYY) and sex.

4. **Insured's Name:** If there is private or group health insurance covering the beneficiary, list the name of the insured (policy holder) here. When the insured and the patient are the same, enter the word SAME. If there is no other insurance, leave blank.

5. **Patient's Address:** Enter the patient's mailing address and telephone number. On the first line, enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

6. **Patient Relationship to Insured:** Check the appropriate box for patient's relationship to insured when item 4 is completed.

7. **Insured's Address:** Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 and 11 are completed.

8. **Patient Status:** Check the appropriate box for the patient's marital status and whether employed or a student.

9 **Other Insured's Name:** If the patient has more than one insurance in addition to Medicaid, enter the primary other insurance information in 11 through 11d and enter the name of the insured for the second commercial insurance here.

9a. **Other Insured's Policy or Group Number**: Enter the second insurance policy or group number.

9b. **Other Insured's Date of Birth and Sex:** Enter the insured's eight-digit date of birth (MMDDCCYY) and check the appropriate box for sex.

9c. **Employer's Name or School Name:** Enter the employer name or school name, if applicable.

9d. **Insurance Plan Name or Program Name:** Enter the plan or program name of the second insurance.

10a. **Is Patient's Condition Related to Employment?:** Check YES or NO as appropriate.

10b. **Is Patient's Condition Related to Auto Accident?:** Check YES or NO. If YES, the two-digit state code must be entered and the date of the accident must be reported in item 14.

10c. **Is Patient's Condition Related to Other Accident?:** Check YES or NO. If YES, the date of the accident must be reported in item 14.

10d. **Reserved for Local Use:** Leave blank. Not used by Medicaid.

11. **Insured's Policy Group or Federal Employee Compensation Act (FECA) Number:** This item MUST be completed if there is other insurance including Medicare. Enter the insured's policy or group number or HIC (Medicare Health Insurance Claim) number and proceed to items 11a. – 11c. Do NOT enter Medicaid information here.

11a. Insured's Date of Birth: Enter the insured's eight-digit date of birth (MMDDCCYY) and sex if different from item 3.

11b. Employer's Name or School Name: Enter the employer's name or school name if applicable.

11c. Insurance Plan Name or Program Name: Enter the complete insurance plan or program name.

11d. Is There Another Health Benefit Plan? If there is a second health benefit plan, mark the YES box and complete fields 9 through 9d. If no other plan, mark NO.

12. Patient's or Authorized Person's signature: Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to MDCH necessary to process the claim.

13. Insured's or Authorized Person's signature: Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to MDCH necessary to process the claim.

14. Date of Current Illness, Injury or Pregnancy: Enter the date of current illness, injury, or pregnancy as appropriate. If YES in item 10b or 10c, the date of accident is required. Report the date as eight digits (MMDDCCYY).

15. If Patient has had a same or similar illness, give first date: Leave blank. Not required by Medicaid.

16. Dates Patient Unable to Work in Current Occupation: Leave blank. Not required by Medicaid.

17. Name of Referring Physician or other Source: Enter the referring/ordering provider's first and last name, and professional designation (e.g., MD, DO). All covered services which are the result of a physician's order or referral must include the referring/ordering physician's name.

17a. I.D. Number of Referring Physician: Enter the nine-digit Medicaid ID number of the referring/ordering provider. The first two digits must be the Medicaid provider type code and the last seven digits must be the Medicaid provider ID number.

Refer to the policy manual for situations where this number may be required. The referring/ordering provider ID number is always required when billing the following services:

- Laboratory Services
- Consultation Services
- Nonemergency Ambulance Services

Ask for the ID number when the referral is made. If the referring/ordering provider is not enrolled in Medicaid, enter nine 8's (888888888). The provider's name and professional designation must be reported in field #17.

18. Hospitalization Dates Related to Current Services: When services are provided during an inpatient hospital stay, enter the date admitted and, if available, the date discharged. Report the dates as eight digits (MMDDCCYY).

19. Reserved For Local Use: If services reported on the claim require documentation or special remarks, enter the information here.

20. Outside Lab/Charges: Leave blank. Not required by Medicaid.

21. Diagnosis or Nature of Illness or Injury: Enter the patient's diagnosis/condition that identifies the reason for the service. You must enter an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). Lab providers may use the laboratory examination code if a diagnosis is not available.

22. Medicaid Resubmission Code and Original Reference Number: Complete only if replacing or voiding/canceling a previously paid claim.

If submitting a replacement claim, enter resubmission code 7 in the left side of item 22 and enter the 10-digit CRN of the paid claim you are replacing in the right side of item 22.

If submitting a void/cancel claim, enter resubmission code 8 in the left side of item 22 and enter the 10-digit CRN of the paid claim you are voiding/canceling in the right side of item 22.

23. Prior Authorization Number: Enter the nine-digit Medicaid authorization number for services requiring authorization. Refer to the policy manual for specific requirements. Following are some of the services that require authorization:

- Elective inpatient services
- Out-of-state ambulance transports
- Select medical equipment and supplies
- Select prosthetic and orthotic services
- Select vision services
- Transplant services
- Other services as described in the provider policy manual or the Medicaid Databases.

Clinical Laboratory Services:

Enter the CLIA number here when billing for clinical lab services. The CLIA number is a 10-digit number with "D" in the third position.

24A. Date(s) of Service: Enter the eight-digit date (MMDDCCYY) for each procedure, service or supply. List each date of service on a separate line. Both the "From" and "To" date must be completed.

Refer to the Special Billing Section for instructions on reporting the date of service in special circumstances.

24B. Place of Service: Enter the appropriate two-digit place of service code from the list of CMS approved definitions for place of service below:

03 **School:** A facility whose primary purpose is education.

04 **Homeless Shelter:** A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

05 **Indian Health Service Free-standing Facility:** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.

06 **Indian Health Service Provider-based Facility:** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.

07 **Tribal 638 Free-standing Facility:** A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.

08 **Tribal 638 Provider-based Facility:** A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatient or outpatient.

11 **Office:** Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12 **Home:** Location, other than a hospital or other facility, where the patient receives care in a private residence.

13 **Assisted Living Facility:** Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24-hours-a-day, 7-days-a-week, with the capacity to deliver or arrange for services, including some health care and other services.

14 **Group Home:** Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and support services and that promotes rehabilitation and reintegration of residents into the community.

15 **Mobile Unit:** A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

20 **Urgent Care Facility:** Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21 **Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.

22 **Outpatient Hospital:** A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 **Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 **Ambulatory Surgical Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 **Birthing Center:** A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.

26 **Military Treatment Facility:** A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

31 **Skilled Nursing Facility:** A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 **Nursing Facility:** A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 **Custodial Care Facility:** A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 **Hospice:** A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

41 **Ambulance – Land:** A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 **Ambulance – Air or Water:** An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

49 **Independent Clinic:** A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

50 **Federally Qualified Health Center:** A facility located in a medically underserved area that provides beneficiaries preventive primary medical care under the general direction of a physician.

51 **Inpatient Psychiatric Facility:** A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 **Psychiatric Facility - Partial Hospitalization:** A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 **Community Mental Health Center:** A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24-hour-a-day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

54 **Intermediate Care Facility/Mentally Retarded:** A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF.

55 **Residential Substance Abuse Treatment Facility:** A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 **Psychiatric Residential Treatment Center:** A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57 **Non-residential Substance Abuse Treatment Facility:** A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

60 **Mass Immunization Center:** A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization

setting, such as a public health center, pharmacy, or mall, but may include a physician office setting.

61 **Comprehensive Inpatient Rehabilitation Facility:** A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 **Comprehensive Outpatient Rehabilitation Facility:** A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

65 **End-stage Renal Disease Treatment Facility:** A facility other than a hospital which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

71 **Public Health Clinic:** A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 **Rural Health Clinic:** A certified facility which is located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

81 **Independent Laboratory:** A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

99 **Other Place of Service:** Other place of service not identified above. (Provide description in item 32.)

Note: MDCH does not recognize place of service 05, 06, 08, 26, 54, or 60 as locations for provision of covered services. Additionally, some locations may be covered only for select providers. Refer to your policy manual for more information.

24C. Type of Service: Leave blank. Not required by Medicaid.

24D. Procedures, Services, or Supplies (CPT/HCPCS Codes plus modifiers): Enter the code for the procedure, service, or supply rendered. Some procedure codes require the use of 2-character modifiers to accurately identify the service provided and to avoid delay or denial of payment. Up to two modifiers can be reported on one service line. If more than two must be reported, use the most pertinent modifier in the first position, modifier 99 in the second position, and identify the additional modifier(s) in item 19. Refer to the Modifier section of this chapter for a list of the modifiers that must be reported to Medicaid. Additional information on use is found in the policy manual. Other modifiers may be reported for informational purposes only.

If a code for the exact procedure cannot be found, use the appropriate unlisted services or Not Otherwise Classified (NOC) code listed within the service classification. Enter a complete description of the service in item 19 or attach the appropriate documentation. Do not use initials or abbreviations, unless they are universally known.

24E. Diagnosis Code (Pointer): Enter the primary diagnosis code pointer or reference number (i.e., 1, 2, 3, or 4) from item 21 which reflects the reason the procedure was performed. The primary diagnosis must always be reported as the first number. An “E” code cannot be reported as a primary diagnosis. Up to 4 pointers (reference numbers) may be reported per line. Do not report the actual diagnosis code in this item.

24F. Charges: Enter your usual and customary charge to the general public. Do not use decimals, commas, or dollar signs. Fifty dollars is recorded as 5000.

When billing Medicaid for services covered by Medicare, report the Medicare allowable amount.

When billing Medicaid for services covered by other third party carriers who have participating provider agreements in effect, report the carrier's allowable amount.

For beneficiaries enrolled in a commercial HMO or a Medicare risk HMO, report the fixed co-pay amount for the service as the charge.

24G. Days or Units: Enter the number of days or units. If only one service is performed, the number "1" must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., mileage, allergy testing, injectable drug dosages, medical supply items). When multiple services are provided, enter the actual number provided.

For anesthesia claims, enter the total anesthesia time in minutes. Convert hours into minutes and enter the total anesthesia minutes provided for the procedure. Do not include base units.

Refer to the policy manual for additional information on billing quantity in special circumstances.

24H. EPSDT/Family Plan: Leave blank. Not required by Medicaid.

24I. EMG – Emergency: Enter the appropriate emergency code:

Y = emergency

N = not an emergency

24J. Coordination of Benefits (COB): For paper claims, enter the appropriate code from the list below. If none of the following conditions apply, leave this item blank. **Note:** Do not bill Medicare covered and excluded services on the same claim.

1 = An insurance carrier other than Medicare made payment. Enter the payment in item 24K.

2 = Commercial HMO fixed co-pay only. Item 24F should be the fixed co-pay amount only.

3 = An insurance carrier other than Medicare applied the charges to the deductible.

4 = Both Medicare and another carrier made payment. Enter the total payment in item 24K.

5 = Medicare only made payment. Enter the payment in item 24K.

6 = Medicare risk HMO co-pay only. Item 24F should be the fixed co-pay amount only.

7 = Medicare applied all charges to the deductible.

8 = The patient has other insurance (other than Medicare) and this service is not covered OR the patient's other insurance is terminated or expired. Indicate the reason for nonpayment in item 19. The policy number of the other insurance must be reported in item 11 even if the other insurance is terminated or expired.

9 = Spend-down liability. Enter the spend-down liability of the patient in item 24K.

Note: The Medicare EOB and/or the other insurance EOB must be submitted with the paper claim if you entered 1, 3, 4, 5, or 7. For electronic claims, the COB codes do not apply. The appropriate segments must be completed as explained in the implementation guide and no EOB is required.

24K. Reserved for Local Use: For Medicaid, report the sum of Medicare payment, and any other insurance payment or spend-down liability. Spend-down liability is the amount that the beneficiary owes for the service. Do not use decimals, commas, or dollar signs.

25. Federal Tax I.D. Number (check box/SSN or EIN): Enter your provider of service or supplier Federal Tax I.D. number (Employer Identification Number) or your Social Security Number. Check the box of the number reported. **Note:** The EIN or SSN reported here must correspond with the billing provider ID# in item 33.

26. Patient's Account Number: Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is to assist you in patient identification. As a service, account numbers reported here will be reported back to you on the remittance advice.

27. Accept Assignment: Leave blank. Not required for Medicaid.

28. Total Charge: Enter total of charges from item 24F, lines 1-6.

29. Amount Paid: Enter the total amount of all payments/spend-down liability reported in item 24K. If you did not indicate the other insurance amount on each service line, enter the lump sum amount in item 29 and attach the EOB to the claim. If there was no other payment, leave blank.

30. Balance Due: Enter the balance due (from Medicaid) by subtracting Amount Paid (item 29) from Total Charge (item 28).

31. Signature of Physician or Supplier including degrees or credentials: A signature is required. See Chapter I for the provider certification requirements and acceptable signatures for the claim form.

32. Name and Address of Facility Where Services Were Rendered (if other than home or office): Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or the physician's office. Use this item to describe where the service was provided when place of service code 99 is used. When the name and address of the facility where the services were furnished is the same as the name and address shown in item 33, enter the word "SAME."

33. Physician's, Supplier's Billing Name, Address, Zip code and Phone #, PIN# and Group #: Enter the provider of service/supplier's billing name, address, zip code and telephone number.

Enter the provider's Medicaid nine-digit provider identification number on the bottom left side of the box next to "PIN#". The first two digits must be the Medicaid provider type code and the last seven digits must be the Medicaid provider ID number. Leave the space right of "GRP#" blank

Note: The provider ID number reported here must correspond with the EIN or SSN reported in item 25.

MANDATORY/CONDITIONAL ITEMS

The following is a summary of mandatory and conditional claim completion requirements by item number.

Mandatory: Item is **required** for all claims. If the item is left blank, the claim cannot be processed.

Conditional: Item is required if applicable. Your claim may not be processed if blank.

Item	Status	Information
1 a	Mandatory	Enter the patient's 8-digit Medicaid ID number.
2	Mandatory	Enter the patient's last name, first name, middle initial, if any.
3	Mandatory	Enter the patient's 8-digit birth date (MMDDCCYY) and sex.
4	Conditional	Mandatory if the patient has insurance primary to Medicaid.
6	Conditional	If item 4 is complete, check the appropriate box.
7	Conditional	Complete if items 4 and 11 are completed.
9	Conditional	Mandatory if item 11d. is YES.
9a	Conditional	Enter second insurance policy or group number for policyholder in item 9.
9b	Conditional	Enter date of birth (MMDDCCYY) and sex for policyholder in item 9.
9c	Conditional	Enter employer or school name for policyholder in item 9.
9d	Conditional	Enter insurance plan name or program name for policyholder in item 9.
10a	Mandatory	Check YES or NO if condition is employment related.
10b	Mandatory	Check YES or NO if condition is related to an auto accident. If YES, indicate the state postal code.
10c	Mandatory	Check YES or NO if condition is related to accident other than auto.
11	Conditional	Mandatory if patient has insurance primary to Medicaid. Enter primary insurance policy group number.
11a	Conditional	Enter the date of birth (MMDDCCYY) and sex for policyholder in item 4.
11b	Conditional	Enter the employer's name or school for policyholder in item 4.
11c	Conditional	Enter the insurance plan or program name for policyholder in item 4.
11d	Conditional	Check YES if appropriate and complete items 9-9d.
14	Conditional	If item 10b or 10c is YES, date of accident must be reported.
17	Conditional	Enter the referring/ordering physician's name as required.
17a	Conditional	Enter the 9-digit Medicaid provider ID# of the provi der in item 17.
18	Conditional	Report the admit & discharge dates for services during an inpatient hospital stay.
19	Conditional	Enter documentation or remarks as required.
21	Mandatory	Enter the ICD-9-CM diagnosis code(s) that identify the reason for the service.
22	Conditional	Resubmit code 7 & the last paid 10-digit CRN is mandatory to replace a previously paid claim. Resubmit code 8 & the last paid 10-digit CRN is mandatory to void/cancel a previously paid claim.
23	Conditional	Enter nine-digit Medicaid authorization number or ten-digit CLIA number as appropriate.
24A	Mandatory	Enter the eight-digit (MMDDCCYY) 'from' and 'to' date for each service.
24B	Mandatory	Enter the appropriate two-digit place of service code.
24D	Mandatory	Enter code and modifier (if appropriate) for the procedure, service or supply rendered.
24E	Mandatory	Enter the reference number(s) from item 21 that relates to the procedure/service. Report the primary diagnosis reference number first.
24F	Mandatory	Enter your charge without decimals, commas, or dollar signs.
24G	Mandatory	Enter the number of units.
24I	Mandatory	Enter appropriate code. Y = emergency N = not an emergency

Item	Status	Information
24J	Conditional	Enter the appropriate COB code to define the involvement of Medicare or other insurance carriers.
24K	Conditional	Report amount of Medicare or other insurance payment or spend-down liability.
25	Mandatory	Enter the provider's Federal Tax I.D. or Social Security Number.
26	Mandatory	Enter the patient account number assigned by the provider or supplier.
28	Mandatory	Enter sum of charges in item 24F.
29	Conditional	Mandatory if entries in item 24K. Enter sum of entries in item 24K.
30	Mandatory	Enter amount in item 28 less amount in item 29.
31	Mandatory	Signature of provider or supplier and date.
32	Conditional	Enter name & address of facility where services were rendered.
33	Mandatory	Enter the provider's 9-digit Medicaid ID number next to "PIN#" for the location of service billed.

REPLACEMENT CLAIMS (ADJUSTMENTS)

Replacement claims are submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDCH made payment. When replacement claims are received, MDCH deletes the original claim and replaces it with the information from the replacement claim. **It is very important to include all service lines on the replacement claim, whether they were paid incorrectly or not.** All money paid on the first claim will be debited and payment will be based on information reported on the replacement claim only. Examples of reasons a claim may need to be replaced:

- to return an overpayment.
- to correct information submitted on the original claim (exception: an incorrect provider ID number or an incorrect beneficiary ID number).
- to report payment from another source after MDCH paid the claim.
- to correct information that the scanner misread (exception: a provider ID number or a beneficiary ID number).

All of the instructions for claim completion apply to completing a replacement claim. **The provider ID number and beneficiary ID number on the replacement claim must be the same as on the original claim.** A replacement claim must also include resubmission code 7 in the left side of Item 22 and the 10-digit CRN of the previously paid claim in the right side of Item 22. If the resubmission code of 7 is missing, the claim cannot be processed as a replacement claim.

Note: If **all** service lines of a claim are rejected, the services must be resubmitted as a new claim. No replacement claim is submitted.

VOID/CANCEL CLAIMS (ADJUSTMENTS)

Void/cancel claims are submitted when a claim was paid under an incorrect provider ID number or under an incorrect beneficiary ID number. When void/cancel claims are received, MDCH deletes the original claim. All money paid on the first claim will be debited. Examples of reasons a claim may need to be voided/cancelled:

- a claim was paid under the wrong beneficiary ID number.
- a claim was paid under the wrong provider ID number.

All of the instructions for claim completion apply to completing a void/cancel claim, except as noted below. **The provider ID number and beneficiary ID number on the void/cancel claim must be the same as on the original claim.** A void/cancel claim must also include resubmission code 8 in the left side of Item 22 and the 10-digit CRN of the previously paid claim in the right side of Item 22. If the resubmission code of 8 is missing, the claim cannot be processed as a void/cancel claim.

Exceptions to claim completion instructions:

If you receive payment under the wrong beneficiary ID number, submit a void/cancel claim using the same beneficiary ID as the original claim, complete one service line and enter zero dollars (000) in all money fields. The entire payment made on the first claim will be debited. A new claim may then be submitted using the correct beneficiary ID.

If you receive payment under an incorrect provider ID number, submit a void/cancel claim using the same provider ID number as the original claim, complete one service line and enter zero dollars (000) in all money fields. The entire payment made on the first claim will be debited. A new claim may then be submitted for the correct provider ID number.

After the void/cancel claim is submitted, a new claim containing the correct beneficiary ID number and/or provider ID number is submitted

Note: If **all** service lines of a claim are rejected, the services must be resubmitted as a new claim. No void/cancel claim is submitted.

REFUND OF PAYMENT

Providers may refund payments to MDCH when the **entire amount paid for a claim** needs to be returned due to overpayment, either from a third party resource or due to an error. This can be done by submitting a replacement claim or a void/cancel claim which results in a debit against a future payment, or can be done manually by submitting a copy of the corresponding RA with a check made payable to "State of Michigan" in the amount of the refund. Manually submitted refunds are sent to:

Department of Community Health
Cashier's Unit
P. O. Box 30437
Lansing, MI 48909

Use of the replacement claim or the void/cancel claim is the preferred method of refunding the entire amount of a previously paid claim.

Note: DO **NOT** submit a replacement claim or a void/cancel claim AND manually send a refund to the Cashier's Unit as this will result in an incorrect refund amount.

GENERAL INFORMATION

Medicaid, State Medical Program, or Children's Special Health Care Services (CSHCS) beneficiaries may lose their eligibility or change enrollment status on a monthly basis. Enrollment status change includes a beneficiary changing from FFS (Fee-For-Service Medicaid or CSHCS) to a Medicaid Health Plan (MHP) or CSHCS Special Health Plan (SHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary.

Note: It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time of treatment and obtain the appropriate authorizations for payment.

INPATIENT HOSPITAL ADMISSION AND SERVICES

The following guidelines are intended to assist providers and health plans with common concerns regarding authorization of services and payment responsibility, particularly when a change in enrollment status has occurred.

- All admissions (other than emergency admissions) require authorization. Medical/surgical (non-psychiatric) admissions must be authorized by the MDCH or it's Admissions and Certification Review Contractor (ACRC)] for FFS, or by the health plan the beneficiary is enrolled in at the time of admission. All psychiatric admissions must be authorized by the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).
- Services provided during the admission may also require authorization for health plan enrollees. Providers must be aware of the beneficiary's enrollment status and of health plan requirements and processes for authorization. Consultations, surgical procedures, and diagnostic tests may not be reimbursed unless a health plan's authorization process is followed.
- If a beneficiary is admitted by the local PIHP/CMHSP, the admission and all psychiatric services are the responsibility of the PIHP/CMHSP. However, any non-psychiatric medical/surgical services needed during a psychiatric admission are the responsibility of the health plan and must be authorized by the health plan. This would include transportation to another facility for medical/surgical services. If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the PIHP/CMHSP must be contacted for authorization and is then responsible for payment for the psychiatric services once authorization has been obtained.
- If a beneficiary is admitted to an inpatient hospital facility and the enrollment status changes during the admission, payment for all services provided until the date of discharge is the responsibility of the payer at the time of admission. Services provided after discharge are the responsibility of the new payer. The discharge planning process should include the new payer for authorization of any medically necessary services or treatments required after discharge from the hospital.
- If a beneficiary is transferred from one inpatient hospital to another inpatient hospital, this <u>does not</u> constitute a *discharge*. The payer at admission is the responsible party until the beneficiary is discharged from the inpatient hospital setting to a non-hospital setting.

Example: A FFS beneficiary is admitted on September 15, enrolled in a health plan on October 1, and was discharged from the hospital on October 5. The health plan is not responsible for services until

October 5, after discharge. FFS is responsible for the entire admission and physician services provided during the admission. The health plan must be contacted at discharge to transition care needs and authorize services needed after discharge, such as rental of equipment, ongoing medical supply needs, ongoing treatment (e.g., home health care, physical therapy, chemotherapy, IV infusion), etc.

Example: If a beneficiary is in health plan "A" during September and changes to health plan "B" for October, health plan "A" is responsible for the admission. Health plan "B" must be contacted during the discharge planning process and is responsible for authorizing all services needed after discharge.

Example: A beneficiary enrolled in health plan "A" is admitted for authorized surgery in June. The beneficiary is enrolled in health plan "B" on July 1. After surgery, the patient develops complications necessitating a transfer to a tertiary hospital on July 2. The beneficiary is subsequently discharged to home on July 6. Plan "A" is responsible for all hospital and physician services through July 6, and plan "B" is responsible for all services needed after discharge.

Example: A health plan beneficiary is admitted for inpatient psychiatric care by a PIHP/CMHSP. During the admission, the beneficiary requires surgery for medical reasons at another facility. The beneficiary's health plan must authorize the surgery and is responsible for paying for transport between the facilities and for charges related to the surgery.

Medicaid beneficiaries who have CSHCS coverage are excluded from enrollment in a Medicaid Health Plan:

- When a beneficiary becomes enrolled in CSHCS, he/she will be disenrolled from the MHP.
- Upon review, MDCH may initiate a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined.
- Responsibility of payment transfers from the MHP to FFS on the effective date of the disenrollment.
- Providers are advised to check the eligibility verification system for changes of enrollment status prior to billing.

MHP beneficiaries who gain CSHCS coverage are disenrolled from the MHP retroactively. Responsibility of payment for the inpatient care during the retroactive time period transfers from the MHP to FFS.

ONGOING SERVICES AND EXTENDED TREATMENT PLANS

It is the provider's responsibility to verify eligibility/enrollment status before each service is rendered, particularly on the first day of a new month. Even though a beneficiary may be involved in an ongoing treatment or care plan, a change in enrollment status will require new authorization from the new responsible party. Enrollment in a health plan will always trigger an authorization process under the new or "current" health plan. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan. The new health plan must assess the need for continuing services and authorize them as appropriate. Health plans should facilitate the transition between providers to ensure continuity of care for the beneficiary.

Example: A beneficiary is in FFS in June. On June 15, the MDCH authorizes a breast reconstruction after mastectomy for breast cancer. The surgery is scheduled for July 20. On July 1, the beneficiary is enrolled in a health plan with the same primary care provider and surgeon. The surgeon must follow

the health plan process for authorization of the reconstructive surgery as the plan is now the payer, not FFS. The MDCH authorization would be void.

Example: A beneficiary is in health plan "A" in July and is involved in a course of physical therapy (PT). The therapy program was authorized for six weeks. On August 1, the beneficiary changes enrollment to health plan "B" and still has two more scheduled weeks of PT. Before PT can continue, the provider must obtain a new authorization from health plan "B." Ideally, as a plan-to-plan change occurs at the request of the beneficiary, the provider would coordinate the transition to the new plan, maintain continuity of care and have an authorization in place from plan "B" so the ongoing PT is not interrupted. However, if PT continues without new plan "B" authorization, plan "A" is not responsible and plan "B" may or may not honor the treatment. The provider cannot bill the beneficiary as the services are covered and it is the provider's responsibility to verify eligibility/enrollment changes and obtain any necessary authorization.

CSHCS Exception: SHP's are responsible for reimbursement of established treatment plans and paying current providers for incoming beneficiaries until an Individualized Health Care Plan (IHCP) is developed. The completed IHCP defines authorized services. Additional services require authorization by the SHP. Established providers will be notified if services are to continue through that provider.

BILLING ISSUES

MDCH policy directs providers to bill the date of delivery for durable items or equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the Comments/Remarks. This is especially important when a beneficiary changes from FFS to a health plan.

In situations where a change in enrollment status occurs during a hospital admission, physician services provided during the admission are the responsibility of the payer for the admission.

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For professional claims, many of the coding conventions described in the CPT manual apply when submitting claims to the MDCH. Additionally, CMS guidelines apply in many instances. Some services may require additional billing information in order to receive correct reimbursement from Medicaid, CSHCS, and SMP. **The old Michigan Uniform Procedure Coding Manual (MUPC) is no longer valid and must not be used for professional claims submitted to Medicaid.**

Do not send documentation with your claim unless you are asked to do so. The use of modifiers replaces documentation requirements in many instances.

If you have unusual circumstances to report, contact our Provider Inquiry staff for help at 1-800-292-2550 or e-mail ProviderSupport@michigan.gov.

AMBULANCE

All non-emergency ambulance services billed to the program must have the referring/ordering physician's name and ID # in items 17 and 17a.

No additional payment is made for the first 30 minutes of waiting time. If more than 30 minutes of waiting time occurs, report the code and enter the appropriate number of time units in item 24g, billing one time unit for each 30 minutes of waiting time over and above the first 30. Documentation regarding the circumstances must be submitted with the claim.

When billing a mileage code, enter the number of whole miles the beneficiary was transported in item 24g. Do not use decimals.

ANCILLARY MEDICINE SERVICES

If an injectable drug is administered on the same day as another service, the administration of the drug is considered a part of the other service and cannot be billed separately. Only the procedure code for the cost of the drug is billed. **If an injectable drug is billed under a non-specific or not otherwise classified (NOC) code, the dose administered and the National Drug Code (NDC) code must be reported in item 19 of the HCFA 1500 or in the appropriate segments of the electronic format. The cost of the drug must be reflected in the charge submitted to the Program. Do not recode injectable drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing Medicaid unless we do not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.**

Chemotherapy drugs and the administration of the chemotherapy drugs are billed separately. Separate payment is also made for chemotherapy administration by push and by infusion techniques on the same day. **If a chemotherapy drug is billed under a non-specific or not otherwise classified (NOC) code, the dose administered and the NDC code must be reported in item 19 of the HCFA 1500 or in the appropriate segments of the electronic format. The cost of the drug must be reflected in the charge submitted to the Program. Do not recode chemotherapy drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing Medicaid unless we do not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.**

Immunizations must be reported using the administration fee code(s) and the code identifying the type of vaccine given. Each vaccine/toxoid given must be reported in addition to the appropriate CPT administration code(s). The immunization administration is covered in addition to the vaccine even if an E/M visit is reported on the same day. Immunizations included in the Vaccine For Children (VFC) and the Vaccine Replacement Program (VRP) programs are free so the charge for these vaccines must be reported as 000 (zero dollars).

For allergy immunotherapy services, only component services are billed. Bill the number of doses of allergy extract or stinging insect venom prepared for and administered to the beneficiary on that date.

For diagnostic tests with global, professional and technical components, practitioners can bill the global service in the ambulatory setting or the professional component service in any setting. Practitioners cannot bill the technical component.

ANESTHESIA SERVICES

Report anesthesia services with the 5-digit CPT anesthesia codes. Only one primary anesthesia service should be reported for a surgical session. Use the anesthesia code related to the major surgery.

Every anesthesia service must have an appropriate anesthesia modifier reported on the service line.

Anesthesia add-on codes are billed in addition to the primary anesthesia code when appropriate. For all non-obstetrical anesthesia add-on codes, payment for the add-on codes is based on established anesthesia base unit values with all time units reported under the primary anesthesia code. For obstetrical anesthesia add-on codes, report the anesthesia time in minutes associated with the add-on code separately from the anesthesia time in minutes associated with the primary anesthesia code.

Report the total anesthesia time in minutes in item 24G. Convert hours into minutes and enter the total anesthesia minutes provided for the procedure. Do not include base units.

If allowable surgical services are reported in addition to the anesthesia procedure, do not report time units for surgical services.

CHILDREN'S WAIVER PROGRAM

Providers must refer to the current CPT and HCPCS codebooks for the full descriptions of the national procedure codes and for additional explanatory information that may affect billing.

In many cases, the units of service for the national procedure codes differ from the units of service for the old Medicaid local procedure codes. In order to correctly bill for services, the full descriptions of the procedure codes must be referred to in conjunction with the current version of Chapter III for Prepaid Inpatient Hospital Plans (PIHPs), Mental Health and Substance Abuse.

If an RN or LPN is providing respite services to more than one beneficiary at the same time, the modifier for RN or LPN must only be reported for one of the beneficiaries for any one unit of service. During that same unit of service, other beneficiaries must be billed using the same procedure code with no modifier reported.

If the same registered nurse or licensed practical nurse provides both private duty nursing services and respite services to the same beneficiary, the record must clearly identify the discreet time spent on each function.

Prior authorization is required from the Children's Waiver Program for each of the following services:

- Home Modifications,
- Repair and non-routine service for medical equipment,
- Van lifts and tie downs with a cost exceeding $5,500.00 or when replacement is needed before 5 years have elapsed. All other vehicle modifications require prior authorization.

Information regarding fee screens and coverage parameters (when appropriate) for covered procedure codes are posted on the MDCH website.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS & SUPPLIES (DMEPOS)

Date(s) of Service (DOS)

For medical supplies, the date supplied must be reported as the date of service. **Exception: For glucose test or reagent strips, lancets, and normal, low, and high calibrator solution, the date of service must be reported as a span date in the "from" and "to" date items, not to exceed one month.**

For the Diaper and Incontinent Supplier Contract, the date the order is transmitted by the contractor to the fulfillment house shall be the date of service.

For both custom and non-custom durable medical equipment (DME) and prosthetics and orthotics (P&O), the date of delivery must be reported as the date of service. If these items are provided for hospital discharge, use the date of release from the hospital as the date of service. For subsequent rental months, if applicable, the DOS must be the first day of the service month based on the original date of delivery.

For custom-made DME or P&O appliances, when there is a loss of eligibility or a change in eligibility status (e.g., from fee-for-service to health plan enrollment or vice versa) between the time the item is ordered and delivered, the order date rather than the delivery date must be reported as the date of service. For payment, the item must be delivered within 30 days after loss or change in eligibility.

For all rented DMEPOS, if a beneficiary's death occurs during a specific month in which payment has already been made, the prorating of actual days the items were used is no longer required.

Days or Units:

For enteral formulae (administered orally or by tube), the appropriate formula HCPCS code should be billed on a monthly basis with total calories used (divided by 100) as the unit amount. To determine the number of caloric units, divide the total number of calories of all cans to be used by 100.

For home intravenous infusion therapy, HCPCS "S" codes must be reported as a daily rate by reporting the total number of days of active infusion as units, unless otherwise noted in the code description. A home infusion therapy code may be billed with modifier "SH" or "SJ" if multiple drugs are being

administered concurrently (e.g., SH – 2 drugs, SJ – 3 drugs). For parenteral intravenous infusion therapy, the appropriate HCPCS "B" codes must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids , the parenteral pre-mix solution , the infusion pump , supply kit , and the administration kit may be billed in combination with each other.

For a powered flotation bed or air-fluidized bed, the rental must be billed as a daily rate by reporting total number of days used as units. (Up to 10 months of rental may be considered for payment.)

Note: For a powered flotation bed or air-fluidized bed, the "MS" modifier is reported only after 10 months of rental have occurred and an additional 6 months of continued maintenance and servicing of the item has been provided. A quantity of "1" must be reported for the entire 6-month period of service.

Hospital Discharge Waiver Services:

In order to bypass the prior authorization requirement when billing for standard DME rentals covered under the hospital discharge waiver service, you must report the discharge date in item 18. **Note:** The discharge date must be entered in the 8-digit MMDDCCYY format.

Converting Rental to Purchase:

If the purchase of an item is requested after a previous rental month(s) has been paid, the provider must subtract this amount from the total purchase price.

Place of Service Codes:

Place of service codes acceptable to report for DMEPOS claims submitted by medical suppliers are as follows:

12 – Home

13 – Assisted Living Facility

14 – Group Home

31 – Skilled Nursing Facility

32 – Nursing Facility

33 – Custodial Care Facility

For residents in a skilled nursing facility or a nursing facility, many medical supplies and/or items of durable medical equipment (DME) are considered a part of the facility's per diem rate. For verification of specific procedure codes that may be billed by the medical supplier, refer to the Medical Supplier Database on the MDCH website.

EVALUATION AND MANAGEMENT SERVICES

CPT E/M service guidelines apply for determining what level of care is appropriate. Generally CPT descriptions for E/M services indicate "per day" and only one E/M service may be reported per date of service.

A preventive medicine E/M visit and another E/M visit on the same date are billed separately if, during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem-oriented E/M visit. When this occurs, bill the

office/outpatient E/M procedure code using modifier 25 and bill the preventive E/M visit without using a modifier. Refer to CPT guidelines for additional information.

If the same level of care E/M visit is provided twice on the same day, report on one service line and use modifier 22. Indicate the time of day for each visit in item 19.

A procedure and a new patient E/M service on the same date should be reported using modifier 25 on the E/M service line.

Consultations require the referring/ordering provider's name and Medicaid ID # in items 17 and 17a.

To report emergency services in the office, report the applicable procedure (e.g., laceration repair) or the E/M office visit that represents the level of care provided.

E/M services provided in the hospital emergency department (ED) by physicians (MD & DO) are reimbursed on a two-tiered case rate. E/M services requiring straightforward, low complexity, or moderate complexity medical decision making are reimbursed at the lower case rate amount. E/M services requiring high complexity medical decision making are reimbursed at the higher case rate amount. Physicians must bill the level of service identified in the CPT coding descriptions to ensure proper reimbursement.

Services such as telephone calls, missed appointments, interpretations of lab results cannot be billed as separate services.

HEARING AIDS

The date of delivery must be reported as the date of service.

When there is a loss of eligibility or a change in eligibility status (e.g., from fee-for-service to health plan enrollment or vice versa) between the time a custom hearing aid is ordered and delivered, the date of service should be reported as the order date rather than the delivery date.

LABORATORY SERVICES

CPT definitions for panels apply. All services in the panel must be provided and each test must be appropriate to the diagnosis or symptom for which the test was ordered.

All clinical lab services billed to the program must have a referring/ordering Medicaid provider name and ID# in items 17 and 17a.

All clinical lab services billed to the program must have a CLIA number in item 23.

If it is medically necessary to repeat the same clinical lab test on the same day for the same patient, report the first test on one line with no modifier and the second on the next line with modifier 91.

MATERNITY CARE SERVICES

CPT guidelines for reporting prenatal care and delivery services apply. Bill the global service as appropriate if the same physician or a single group practice provides prenatal care, delivery and postpartum care.

The individual prenatal care or delivery codes must only be billed when different physicians (not in the same group) provide the services.

The number of prenatal visits may vary depending on when the beneficiary first seeks care. Typically, a beneficiary will have about 13 visits. For a high-risk pregnancy, report the appropriate E/M service when additional visits (beyond 13) are required for the high-risk condition. The diagnosis must be for the high-risk condition.

Postpartum care is only billed as a separate service when provided by a physician or group practice that did not perform the delivery services.

For twin gestation, report the service on two lines with no modifier on the first and modifier 51 on the second. If all maternity care was provided, report the global OB service for the first baby, and report the appropriate delivery-only code for the second baby using modifier 51. If multiple gestation for more than twins is encountered, report the first service on one line and combine all subsequent deliveries on the second line with modifiers 51 and 22. Provide information in item 19 or submit an attachment to the claim explaining the number of babies delivered.

NEWBORN CARE

When billing the Program for medical services provided to the newborn, providers **must use the newborn's Medicaid ID number.** The mother's Medicaid ID number cannot be used.

Exception: If the newborn's care and circumcision are performed by the delivering physician during the mother's inpatient stay, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.

PRIVATE DUTY NURSING

When submitting claims for private duty nursing services, the provider must observe the following:

- The Place of Service Code on the claim must indicate **Home**.
- Each date of service must be reported on a separate service line.
- Each service line must contain the number of hours of care in the Days or Units item for that date of service.
- The prior authorization number listed on the Medicaid authorization letter must be recorded on the claim.
- The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.
- A plan of care IS NOT TO BE ATTACHED TO THE HCFA 1500 OR OTHERWISE SUBMITTED TO THE MEDICAID PROGRAM UNLESS SPECIFICALLY REQUESTED TO DO SO BY THE PROGRAM.
- The **total** number of hours reported must not exceed the total hours that were authorized for that month.
- Since whole hours of care are authorized, only those hours of care that entail a full hour of care are billed.

- Adjustments to claims are made through a total claim replacement or void/cancel process.

Multiple Beneficiaries Seen At Same Location:

The appropriate procedure codes must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These procedure codes must be used for EACH beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, the multiple beneficiary code must be used for both children. Procedure codes to be used for billing private duty nursing are available on the MDCH website in the private duty nursing database.

Holidays:

The Program allows additional reimbursement for holidays on which private duty nursing services are provided. Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas Day.

A holiday begins at 12:00 a.m. and ends at 12:00 midnight.

RADIOLOGY SERVICES

If bilateral x-rays are performed on extremities, report on two service lines with modifier RT on one and modifier LT on the other.

If the same x-ray is performed multiple times on the same beneficiary on the same day, (e.g., before and after fracture care) report the appropriate quantity in item 24G.

For radiology services with global, professional and technical components, practitioners can bill the global service in the non-hospital setting or professional component service in any setting. Practitioners cannot bill the technical component only.

SCHOOL-BASED SERVICES

When submitting claims, School-Based Services providers must observe the following:

- Procedure codes that specify time intervals cannot be billed until and unless the time unit specified is reached. Providers cannot bill less than a full unit or a partial unit and cannot "round up" to the next unit of service.
- For procedure codes billed by time units, such as per 15 minutes, the time specified in the procedure code description equals one unit of service.
- Procedure codes that are not billed by time units are billed per encounter.
- Each qualified staff bills for their evaluations, tests, and related activities for the Individuals with Disabilities Education Act (IDEA) assessment using the appropriate procedure code with the modifier HT. The date of service is the date the evaluations are completed.
- Each qualified staff bills for their participation in the development, review, and revision of an individualized education program (IEP)/individualized family service program (IFSP) using the appropriate procedure code with the modifier TM. The date of service is the date of the IEP/IFSP meeting.

- Evaluations/assessments may be provided that are not related to the IDEA assessment or IEP/IFSP development, review, and revision. When this occurs, bill the appropriate evaluation/assessment procedure code for that profession with NO modifier. The date of service is the date the evaluation/assessment is completed.
- The psychologist, counselor, and social worker can bill for their evaluations/assessments using the same procedure code for the same date of service. When this occurs, bill on one service line and indicate the total number of units provided for that date of service. The evaluations/assessments that are performed on the same day for the same student must be for different purposes and not be duplicative. The date of service is the date the evaluations/assessments are completed.

SURGERY

CPT surgery guidelines for add-on codes, separate procedures, and bilateral services generally apply.

CMS's global surgery guidelines apply. Use the appropriate modifiers to identify what service was provided.

When reporting post-operative care only for surgical procedures with 10-day or 90-day global periods, the provider assuming the post-operative care must bill the date of the surgery and the appropriate surgical code with modifier 55. The claim cannot be submitted until after the patient is seen. Report the date care was assumed/relinquished in item 19.

For multiple surgical procedures performed during the same surgical session, report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier 51.

If two identical surgical or procedural services are provided on the same day to the same beneficiary, and cannot be reported as a bilateral procedure, bill on two service lines with no modifier on the first line and modifier 51 on the second line. Multiple surgery rules apply. If more than two identical services are provided on the same day, the second and subsequent identical services must be combined on the second line. Report modifiers 51 and 22 and provide an explanation of the circumstances.

If a bilateral procedure is performed, report the bilateral code if available. When there is no code describing bilateral services, report the service on one line and use modifier 50.

Sterilization and hysterectomy consent forms may be faxed to the program for acknowledgement of proper completion before the service is billed to the program. The fax number is 1-517-241-7856. If completed properly, there is no need to submit a copy of the form with the claim. Indicate "consent on file" in item 19. For Medicaid Health Plan enrollees, the provider must contact that health plan for specific requirements related to these consent forms.

VISION

A routine eye examination includes, but is not limited to, case history, determination of visual acuity (each eye), ophthalmoscopy, biomicroscopy, ocular motility, tonometry, refraction, diagnosis, treatment program, and disposition. Ophthalmologists and optometrists must use appropriate CPT/HCPCS code(s) for the service.

Non-routine eye examinations for the purpose of evaluation and treatment of chronic, acute, and/or sudden onset of abnormal ocular symptoms must be billed using the appropriate CPT/HCPCS codes.

Glaucoma screening must be billed with the appropriate CPT/HCPCS procedure codes. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening will not be allowed.

Note: If the beneficiary presents with a visual or ocular complaint, the glaucoma screening procedure code should **not** be used. A procedure code which best describes the encounter should be selected from the E/M or General Ophthalmological codes.

Covered CPT/HCPCS codes are listed in the Vision Services Database and, where noted by status code "P", prior authorization is required.

Report the date eyeglasses are dispensed as the date of service in item 24A. If eligibility or enrollment status changes after eyeglasses are ordered but before they are delivered, the order date of the eyeglasses must be reported as the date of service in item 24A.

BILLING INFORMATION FOR THIRD PARTY COVERAGE

Providers must always identify third party resources and report third party payments in the appropriate field(s) on the claim. Third party resources must be identified even when the services are not covered by that payer.

Medicare covered services must be submitted on one claim and any excluded services must be submitted on a separate claim. Do not mix covered and excluded services on the same claim.

The provider must indicate Medicare's allowable amount as the charge (item 24F) and report the actual payment and/or deductible as instructed.

If the beneficiary is in a Medicare risk HMO, the fixed co-pay must be entered in item 24F and enter COB code 6 in item 24J.

If the beneficiary is in a commercial plan with fixed co-pays, the co-pay must be entered in item 24F and enter COB code 2 in item 24J.

If payments are made by a commercial insurance, the amount paid, whether it is paid to the provider or the policyholder of the insurance, must be entered in item 24K on each service line as appropriate.

If the beneficiary's spend-down amount is met in the middle of a service so that part of the charge is the beneficiary's responsibility and part is Medicaid's responsibility, enter the full charge for the service in item 24F of the service line. Enter COB code 9 in item 24J and enter the amount of the beneficiary's liability in item 24K.

When billing on the HCFA 1500 paper claim form, the provider must submit evidence of other insurance responses (explanation of benefits, denials, etc.) when billing MDCH for covered services.

If billing electronically, no EOB is necessary, as all required data are part of the electronic format. However, in ALL cases where a provider is billing on the HCFA 1500 claim form, a copy of the Medicare EOB MUST be submitted with the claim.

MDCH cannot be billed for co-pays, deductibles, or any other fee for services provided to beneficiaries enrolled in a MHP, SHP, or who are receiving services under PIHP/CMHSP or CA capitation. Payment for services must be obtained from the MHP/SHP/PIHP/CMHSP/CA. **For detailed information related to third party billing, including Medicare and commercial insurance, refer to the Coordination of Benefits chapter of this manual.**

MISCELLANEOUS

All unlisted or not otherwise classified (NOC) codes require documentation of the services provided in order to be considered for payment. **Do not recode procedure codes submitted to Medicare or other insurers to unlisted or NOC codes when billing Medicaid unless we do not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.**

Note: Claims will be rejected for inappropriate recoding even if prior authorization was issued by MDCH.

Use ICD-9-CM coding conventions to report the diagnosis code(s) at the highest level of specificity. E-codes cannot be reported as a primary diagnosis. If an E-code is reported as primary, or if a code requiring a fourth or fifth digit is reported with fewer digits (truncated), the claim cannot be paid.

For elective services requiring prior authorization, authorization must be obtained before providing the service. If approved, a letter confirming coverage or denial of the service will be sent back to you along with a nine-digit PA number. **Do not submit the letter to the program when billing. Report the PA number in item 23.**

Procedure codes may be modified under certain circumstances to more accurately represent the service or item rendered. There are two levels of modifiers recognized by the Program: Level I being those included in CPT and updated annually by the American Medical Association, and Level II recognized nationally and updated annually by CMS.

Definitions and use of Level I modifiers can be found in the annual edition of the CPT. Definitions of Level II modifiers are found in the annual edition of the HCPCS procedure coding manual. Providers should refer to these manuals and their policy manual for more information on the use of these modifiers.

The modifiers listed below must be reported when applicable and affect the processing and/or reimbursement of claims billed to the MDCH for Medicaid, CSHCS, and SMP beneficiaries. Other Level I and Level II modifiers may be used to provide additional information about the service or may be required by other payers but will not affect the processing of your Medicaid claim.

AMBULANCE

When billing for ambulance services, providers must include the appropriate origin and destination modifier on any service line when billing for mileage. The first character of the modifier is the origin code and the second character of the modifier is the destination code. (e.g., use modifier RH for a transport from the residence to the hospital.)

Origin and Destination Modifiers

D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Non-hospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

When billing for a transport when more than one patient is transported at one time, the appropriate modifier must be reported on the service line for the transport for the second or subsequent patient being transported. This modifier is not reported for the first patient.

GM	Multiple patients on one ambulance trip	Enter on the transport service line for 2nd or subsequent patient when more than one patient is transported. Reduces reimbursement for the 2nd or subsequent patient transported. Do not report for the first patient.

ANESTHESIA

Anesthesia services billed without an appropriate modifier will be rejected.

47	Anesthesia by Surgeon	Anesthesia procedure codes billed with this modifier will not be paid. General anesthesia provided by the surgeon is not covered.
AA	Anesthesia Services Performed Personally By Anesthesiologist	Determines reimbursement for anesthesia services reported with codes 00100-01999.
AD	Medical Supervision By A Physician: More Than Four Concurrent Anesthesia Procedures	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QK	Medical Direction Of 2, 3 or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QX	CRNA service with medical direction by a physician	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QS	Monitored anesthesia care service	Report in addition to the appropriate anesthesia modifier to identify MAC services reported with codes 00100-01999.
QZ	CRNA service: without medical direction by a physician	Determines reimbursement for anesthesia services reported with codes 00100-01999.

CHILDREN'S WAIVER PROGRAM

TD	RN	Report in addition to the appropriate procedure code for respite when the service is provided by a registered nurse.
TE	LPN/LVN	Report in addition to the appropriate procedure code for respite when the service is provided by a licensed practical nurse.
TT	Individualized service provided to more than one patient in same setting	Report in addition to the appropriate procedure code for respite when more than one beneficiary is receiving the service at the same time from the same provider.

COMPONENT BILLING

Certain procedures are a combination of a professional component and a technical component and must be reported in order to receive reimbursement.

26	Professional Component	Must be reported when billing only the professional component of a procedure. Providers are limited to billing the professional component for certain services in a facility setting.
TC	Technical Component	Reserved for facility billing. Practitioners should not report.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS & SUPPLIES (DMEPOS)

For surgical dressings, report modifiers "A1" through "A9" depending on number of wounds being treated.

For DME items, the new equipment modifier "NU" or the used equipment modifier "UE" must be reported for all applicable procedure codes.

For all lower extremity prostheses, modifiers "K0" through "K4" must be reported to designate the potential functional ability of a beneficiary (before a prosthesis is furnished) based on the reasonable expectations of the prosthetist and treating physician.

For orthotic and prosthetic items, the "LT" or "RT" modifier is required to designate either the left or right side of the body if applicable. Refer to the Medical Supplier fee screen database for additional information. When reporting bilateral orthotic or prosthetic items on the same DOS, the "LT" and "RT" modifiers must be listed on the same service line with the combined quantities of both items. To verify the specific HCPCS codes that require these modifiers, refer to the medical supplier database on the MDCH website.

For DME and prosthetic/orthotic items, the "RP" modifier is required when billing the repair of an item involving the **replacement of a component part.** The reimbursement includes the cost of the part and the labor associated with its removal, replacement and finishing.

For a powered flotation bed or air fluidized bed, the "MS" modifier is reported only after 10 months of rental have occurred and an additional 6 months of continued maintenance and servicing of the item has been provided. A quantity of "1" must be reported for the entire 6-month period of service.

A1	Dressing for one wound	Use to report surgical dressings
A2	Dressing for two wounds	Use to report surgical dressings
A3	Dressing for three wounds	Use to report surgical dressings
A4	Dressing for four wounds	Use to report surgical dressings
A5	Dressing for five wounds	Use to report surgical dressings
A6	Dressing for six wounds	Use to report surgical dressings
A7	Dressing for seven wounds	Use to report surgical dressings
A8	Dressing for eight wounds	Use to report surgical dressings
A9	Dressing for nine or more wounds	Use to report surgical dressings
BO	Orally administered nutrition, not by feeding tube	Use to report oral administration of enteral nutrition
K0	Lower extremity prosthesis functional level 0 – does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does **not** enhance their quality of life or mobility.	Use to report functional level capability of beneficiary

K1	Lower extremity prosthesis functional level 1 – has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.	Use to report functional level capability of beneficiary
K2	Lower extremity prosthesis functional level 2 – has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.	Use to report functional level capability of beneficiary
K3	Lower extremity prosthesis functional level 3 – has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.	Use to report functional level capability of beneficiary
K4	Lower extremity prosthesis functional level 4 – has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.	Use to report functional level capability of beneficiary
LT	Left Side of the Body (used to identify procedures performed on the left side of the body)	Must be reported with select prosthetic and orthotic items to identify the left side of the body for use. Also will allow payment of bilateral RT and LT devices placed on the same date of service.
MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	Use with HCPCS codes E0193 or E0194 after six months of continued maintenance and servicing following the initial 10 months of rental
NU	New DME equipment	Use for the purchase of a new DME item.
RP	Replacement and repair: "RP" may be used to indicate replacement of DME, orthotic and prosthetic devices which have been in use for some time. The claim shows the code for the part, followed by the "RP" modifier and the charge for the part.	Replacement of a component part of a DME, orthotic or prosthetic item includes the cost of the part and the labor associated with its removal, replacement and finishing. When billing this service, report the "RP" modifier with the specific HCPCS code.
RR	Rental (use the "RR" modifier when DME is to be rented)	For monthly rental rate of DME items.
RT	Right Side of the Body (used to identify procedures performed on the right side of the body)	Must be reported with select prosthetic and orthotic items to identify the right side of the body for use. Also will allow payment of bilateral RT and LT devices placed on the same date of service.
SH	Second concurrently-administered infusion therapy	Must be reported with HCPCS "S" home infusion codes to specify two concurrently-administered drugs.
SJ	Third or more concurrently-administered infusion therapy	Must be reported with HCPCS "S" home infusion codes to specify three concurrently administered drugs.

UE	Used durable medical equipment	Use for the purchase of used DME equipment that is not over 3 years old and meets the Medicaid requirements for equipment.

EVALUATION AND MANAGEMENT SERVICES

21	Prolonged Evaluation and Management Services	Use to report a service that is greater than that usually required for the highest level of an evaluation and management service. A report or remarks explaining the service is required.
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	E&M services unrelated to the surgery and billed by the surgeon during the postoperative period of a global surgery are not payable without this modifier.
25	Significant, Separately Identifiable Evaluation and Management Services by Same Physician on Same Day of the Procedure	E&M services reported without modifier 25 and billed in addition to other procedures/services on the same day are not payable. Allows significant separately identifiable E&M services to be paid without review. Subject to postpayment audit.
57	Decision for Surgery	Required for an E & M service provided the day of or the day before a procedure with a 90-day global period to indicate that the service was for the decision to perform the procedure.

GENERAL BILLING

22	Unusual Procedural Services	Report/remarks required.
99	Multiple Modifiers	Identifies that more modifiers are necessary than allowed by the format (2 on paper claims or 4 in the electronic format). The second or fourth modifier must be "99" and the additional modifiers must be indicated in item 19 or the appropriate electronic remark area.
EP	Service provided as part of Medicaid EPSDT program	Used with procedure code T1028 to determine reimbursement.
GC	Service performed by resident under direction of teaching physician.	Report to identify services provided by resident in presence of teaching physician.
GE	Service performed by resident under primary care exception	Report to identify primary care services provided by a resident without the presence of the teaching physician under the primary care exception.
LT	Left side (used to identify procedures performed on the left side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.
Q5	Service furnished by substitute physician under a reciprocal billing arrangement	The name of the physician providing the service must be reported in item 19.
Q6	Service furnished by a locum tenens physician	The name of the physician providing the service must be reported in item 19.
RT	Right side (used to identify procedures performed on the right side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.

TS	Follow-up service	Used with procedure code T1029 to determine reimbursement.

LABORATORY

90	Reference Lab	Identifies that services were referred to specialty lab.
91	Repeat Clinical Diagnostic Laboratory Test	Use to identify a medically-necessary repeat test done on same date.
QW	CLIA waived test	Identifies CLIA-waived tests as required.

MEDICARE

Any service reported to Medicaid for a Medicare/Medicaid eligible beneficiary that is an excluded or non-covered Medicare benefit must be identified with modifier GY or GZ on the service line.

GY	Excluded Medicare Benefit	Report this modifier to identify services that are excluded from Medicare coverage. Also report to identify services for aliens 65 years old and older.
GZ	Medicare denied as not reasonable or necessary	Report this modifier to identify services determined not reasonable or necessary by Medicare.

PRIVATE DUTY NURSING

TT	Individualized service provided to more than one patient in same setting	Use this modifier with procedure codes S9123 and S9124 when private duty nursing services are being provided to more than one beneficiary at one time.

SCHOOL-BASED SERVICES

HT	Multi-disciplinary team	Use this modifier with the appropriate evaluation procedure codes to identify participation by each qualified profession in the IDEA assessment.
TM	Individualized Education Program (IEP)	Use this modifier with the appropriate procedure codes to identify participation by each qualified staff in the development, review, and revision of the (IEP).

SURGICAL ASSISTANCE

80	Assistant Surgeon	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79, the claim will not be paid.
81	Minimum Assistant Surgeon	Use modifier 80 or 82 to bill surgical assistance. Claims billed with modifier 81 will be rejected.

82	Assistant Surgeon (when qualified resident surgeon not available)	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79, the claim will not be paid.
AS	PA, NP, or CNS services for assistant at surgery	Reimbursement for services adjusted to CMS limits for reimbursement for these practitioners.

SURGICAL SERVICES

50	Bilateral Procedure	Report to identify that bilateral procedures were performed during the same operative session. Reimbursement is 150% of the fee for the procedure or the provider's charge if bilateral reporting is appropriate.
51	Multiple Procedure	Use to report multiple procedures during the same operative session. Report on each additional procedure, not on the primary procedure. Determines payment at 100%, 50%, 50%, etc. when appropriate.
52	Reduced Services	Report if a service or procedure is partially reduced or eliminated at the physician's discretion. A report or remarks are required to determine reimbursement.
53	Discontinued Procedure	Report if a surgical or diagnostic procedure is terminated after it was started. A report or remarks are required to determine reimbursement.
54	Surgical Care Only	Reported by the surgeon for surgical procedures with 10- or 90-day global periods when all or part of the post operative care is relinquished to a physician who is not a member of the same group. Reimbursement will reduced to the surgical care rate only.
55	Postoperative Management Only	Reported by the physician furnishing postoperative management only. Report the surgical procedure with the date of surgery and the date care was relinquished/assumed in item 19.
56	Preoperative Management Only	Do not report. Preoperative management is part of the surgical care and is not covered separately. Claims billed with modifier 56 will be rejected.
58	Staged Or Related Procedure Or Service By The Same Physician During The Postoperative Period	Allows payment for subsequent surgical procedures performed during the global surgery period that meet certain requirements. Do not use in place of modifier 78.
59	Distinct Procedural Service	Report/remarks required. Do not report if another modifier is more appropriate.
62	Two Surgeons	Determines reimbursement when two surgeons were involved in the same surgery.
66	Surgical Team	Determines reimbursement for complex surgery requiring a surgical team. A report or remarks are required.
76	Repeat procedure by same physician	Report when a procedure or service is repeated by the same physician subsequent to the original service.
78	Return to the Operating Room for a Related Procedure During the Postoperative Period	When appropriate, allows payment for related services (complications) requiring a return to OR during the postoperative period. Payment is reduced to operative care only.

79	Unrelated Procedure or Service by Same Physician During Postoperative Period	When appropriate, allows payment for services during the postoperative period unrelated to the original surgery.

VISION

U1	Polycarbonate lenses	Determines payment rate to contractor.
U2	High index lenses	Determines payment rate to contractor.
VP	Aphakic patient	Report to identify that service is for aphakic patient.
55	Postoperative management only	Reported by an optometrist (with TPA certification) for select services when a physician performs the surgical procedure and relinquishes the follow-up care to the optometrist.

PAYMENTS/CLAIM STATUS

The MDCH processes claims and issues payments (by check or electronic funds transfer [EFT]) every week unless special provisions for payments are included in your enrollment agreement. A Remittance Advice (RA) is issued with each payment to explain the payment made for each claim. If no payment is due, but claims have pended or rejected, an RA will also be issued. If claims are not submitted for the current pay cycle, no action is taken on previously pended claims, or no payment gross adjustments are processed in the pay cycle, an RA is not generated.

If the total amount approved for claims on any one RA is less than $5.00, a payment is not issued for that pay cycle. Instead, a balance is held until approved claims accumulate to an amount equal to or more than $5.00. Twice a year (usually June and December) all amounts of less than $5.00 are paid.

If a claim does not appear on an RA within 30 days of submission, a new claim should be submitted. The provider should verify that the provider ID# and beneficiary ID# are correct.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with the MDCH under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from the MDCH through EFT must register through the Department of Management and Budget's (DMB) website. See the Directory Appendix for DMB website information.

REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. See the Directory Appendix for contact information.

ELECTRONIC REMITTANCE ADVICE (835 HEALTH CARE CLAIM PAYMENT/ADVICE)

The electronic RA is produced in the HIPAA-compliant ANSI X12N 835 version 4010A1 format. Providers opting to receive an electronic RA will receive all information regarding adjudicated (paid or rejected) claims in this format. Information regarding pended claims will be reported electronically in the 277 Unsolicited Claim Status format.

The electronic RA has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems
- It includes a MDCH trace number to identify the associated warrant or electronic transfer (EFT) payment
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim
- It contains additional informational fields not available on the paper RA

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle will report on a single 835 and/or 277U, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835/277U transaction must identify a primary service bureau to receive the 835/277U. All providers under the same corporate TIN must utilize the same primary service bureau. An addition of and/or change to the identification of the primary service bureau must be submitted to Provider Enrollment. The primary service bureau will be the only one to receive the 835/277U remittance information for all claims regardless of submission source. No other service bureau submitting claims for that provider/group TIN will receive information regarding claims submitted.

For more information regarding the 835 and 277U transactions issued by the MDCH, refer to the MDCH companion guides on the Department's website. For general information about the 835 and 277U, refer to the Implementation Guides for these transactions. The implementation guides are available through the Washington Publishing Company. See the Directory Appendix for contact information.

PAPER REMITTANCE ADVICE

All providers with approved or pended claims will receive a paper RA, even if they opt to receive the 835/277U transactions.

The following information is supplied on the paper RA Header:

- **Provider ID No. and Provider Type:** This is the Medicaid provider ID# from the provider's claim. The first two digits of the Provider ID# appear in the Provider Type box and the last seven digits appear in the Provider No. box.
- **Provider Name:** This is from the MDCH provider enrollment record for the provider ID# submitted on the claim.
- **Pay Cycle:** This is the pay cycle number for this RA.
- **Pay Date:** This is the date the RA is issued.
- **Page No:** Pages of the RA are numbered consecutively.
- **Federal Employer ID Number or Social Security Number:** This is in small print in the upper right corner and is unlabeled. The number on the provider's claim must match the billing provider ID# on file with the MDCH and it must be a valid number with the Michigan Department of Treasury. MDCH cannot issue a check if there is a discrepancy between the number on file with the MDCH and the Michigan Department of Treasury. (Incorrect information should be reported to the Provider Enrollment Unit. See the Directory Appendix.)

Claims appear on the RA in alphabetical order by the beneficiary's last name. If there is more than one claim for a beneficiary, they appear in Claim Reference Number (CRN) order under the beneficiary's name.

Claim Header:

- **Patient ID Number:** The beneficiary's Medicaid ID number that the provider entered on the claim.
- **Claim Reference Number (CRN):** A 10-digit CRN is assigned to each claim. If the claim has more than one service line, the same CRN is assigned to each line. The first four digits are the

Julian Date the claim was received by MDCH. The fifth through tenth digits are the sequential claim number assigned by the MDCH.

Example: In CRN 3223112345, 3 is the year 2003, 223 is the Julian day of the year (August 11), and 112345 is the sequence number. The combination of Julian day and sequence makes a unique number that is assigned to each claim. When asking about a particular claim, the provider must refer to the CRN and Pay Date.

The 10-digit CRN is followed by a two-character input ID (3223223445-XX). If a service bureau submitted the claim, this will be the service bureau ID. If the provider submitted a paper claim, this will be a scanner identifier.

- **Line No.:** This identifies the line number where the information was entered on the claim.
- **Invoice Date:** This identifies the date the provider entered on the claim or, if left blank, the date the claim was processed by the system.
- **Service Date:** This identifies the service date entered on the claim line (admit date for inpatient service).
- **Procedure Code:** This identifies the procedure code or revenue code entered on the service line.
- **Qty:** This identifies the quantity entered on the service line. If the MDCH changed your quantity, an informational edit will appear in the Explanation Code column.
- **Amount Billed:** This identifies the charge for the entire claim.
- **Amount Approved:** This identifies the amount the MDCH approved for the service line. Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from MDCH. **Example:** when other resources made a payment greater than MDCH's usual payment.
- **Claim Adjustment Reason Code:** Claim adjustment reason codes communicate why a claim or service line was paid differently than was billed. If there is no adjustment to a claim line, then there is no adjustment reason code.
- **Claim Remark Code:** Claim remark codes relay service line specific information that cannot be communicated with a reason code.
- **Invoice Total:** Totals for the Amount Billed and the Amount Approved print here.
- **Insurance Information:** If Medicaid beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g., vision, medical) print below the last service line information.
- **History Editing:** Certain edits compare the information on the claim to previously paid claims. In some cases, information about the previous claim will print on the RA. This information prints directly under the service line to which it relates.
- **Page Total:** This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two PA pages, the page total will include only the paid lines printed on each RA page.

  NOTE: Amounts for pended service lines and rejected service lines are not included on the Page Total.

All hospitals on the Medicaid Interim Payment (MIP) program have “MIP” PROGRAM printed on the bottom of each page.

GROSS ADJUSTMENTS

Gross adjustments are initiated by the MDCH. A gross adjustment may pertain to one or more claims.

MDCH notifies providers, in writing, when an adjustment will be made. The provider should receive the notification before the gross adjustment appears on the RA.

The paper RA will indicate gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes will be used. Code definitions can be found at the Washington Publishing Company website.
- **Gross Adjustment Code:** This is the MDCH gross adjustment code that corresponds to the gross adjustment description.
- **GACR** is a Gross Adjustment Credit. This appears when the provider owes MDCH money. The gross adjustment amount is subtracted from the provider's approved claims on the current payroll.
- **GADB** is a Gross Adjustment Debit. This appears when MDCH owes the provider money. The gross adjustment amount is added to the provider's approved claims on the current payroll.
- **GAIR** is a Gross Adjustment Internal Revenue. This appears when the provider has returned money to the MDCH by check instead of submitting a replacement claim. It is subtracted from the Year-To-Date (YTD) Payment Total shown on the summary page of the RA.

REMITTANCE ADVICE SUMMARY PAGE

The Summary Page is the last page of the RA and gives totals on all claims for the current payroll and year-to-date totals from previous payrolls.

- **This Payroll Status:** This indicates the total number of claims and the dollar amount for the current payroll. This includes new claims plus your pended claims from previous payrolls that were paid, rejected, or pended on the current payroll.
- **Approved:** This is the number of claims from this payroll with a payment approved for every service line. The dollar amount is the total that the MDCH approved for payment.
- **Pends:** This is the number of claims from this payroll that are pending. The dollar amount is the total charges billed.
- **Rejected:** This is the number of claim lines from this payroll that were rejected. The dollar amount is the total charges billed.
- **App'd/Rejected:** This is the number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total approved, and the amount next to Rejected Claim Lines is the total charge billed.
- **Total Pends in System:** This is the total number of new and unresolved pended claims in the system and total charges.
- **Previous YTD (Year-To-Date) Payment Total:** This is the total amount paid to the provider for the calendar year before any additions or subtractions for this payroll.

- **Payment Amount Due This Payroll To Provider:** This amount is the Payment Amount Approved, plus any balance due to the provider, and minus any balance owed by the provider to MDCH.
- **Payment Made This Payroll:** This is the amount of the check or EFT issued for this payroll.
- **New YTD Payment Total This Payroll:** This is the total payment for the calendar year, including payments made on this payroll.
- **Balance Owed or Balance Due:** One or more of the following prints if the provider has a balance owed or a balance due.
  - **Balance Due to Provider by MDCH:** This appears if the payment amount approved is less than $5.00 or a State account is exhausted.
  - **Balance Owed by Provider to MDCH:** This appears when money is owed to MDCH, but the provider does not have enough approved claims from a particular State account (e.g., CSHCS or SMP) to deduct what is owed.
  - **Previous Payment Approved, Not Paid:** This appears if a balance is due from MDCH on the previous payroll.
  - **Previous Payment Owed by Provider to MDCH:** This prints when a balance is due from the provider on a previous payroll.
- **Pay Source Summary:** This identifies the dollar amounts paid to the provider from the designated State accounts.

PENDED AND REJECTED CLAIMS

When claims are initially processed, the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid, rejected or pended and lists codes that apply.

Rejections: If a service line is rejected, a Claim Adjustment Reason/Remark code will print in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definitions of the codes to determine the reason for the rejection.

Pends: If any service line pends for manual review, PEND prints in the Claim Adjustment Reason/Remark column of the RA. These pended claims will not print again on the RA until:

- The claim is paid or rejected, or
- Is pended again for another reason, or
- Has pended for 60 days or longer.

Note: After a claim initially pends, it may pend again for a different reason. In that case, the symbol # will print in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.

When a claim is pended, the provider must wait until it is paid or rejected before submitting another claim for the same service.

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JULIAN CALENDAR

Day 'Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

For leap year, one day must be added to number of days after February 28. The next three leap years are 2004, 2008 and 2012.

Example: claim reference # 1351203770-59
1 = year of 2001
351 = Julian date for December 17
203770 = consecutive # of invoice
59 = internal processing

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