Hearing and Audiology

October 11, 2022

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

-Provider Relations

Table of Contents

Policy Overview

- Overview of Hearing aid coverage, covered services, etc.
- Attending/Ordering/Referring Claim Editing change - MSA 21-45

MDHHS
Michigan Department of Health & Human Services

Policy Overview

Hearing Aid Contract

- MDHHS participates in a volume purchase contract agreement for hearing aids.
- Providers must purchase hearing aids directly from the manufacturers that are part of the contract whenever possible.
- Providers must bill and are reimbursed the contract price for the hearing aid.
- Hearing Aid Contract Models
- The Hearing Aid Contract Vendor listing is maintained on the MDHHS website.
    - Hearing Aid Contract Vendor Contact List

Hearing Aid Coverage

Medicaid covers the following hearing aid services and items when provided by a licensed hearing aid dealer, hearing center, or audiologist:

- Hearing aids (Digital and CROS/BICROS Models) (1 per 5 yr)
- Repairs and modifications
- Earmolds (1 per yr. Additional allowed for beneficiaries under 21 years of age. See schedule in Provider Manual.)
- Supplies and accessories (up to $40 per year. Item listing is maintained on MDHHS website.)
- Batteries (72 per yr per aid)
- Conformity evaluations (2 per yr)
- Routine checks, fittings, & programming (2 per yr)
- Hearing Aid Supplies and Accessories Resource
- Hearing Services and Devices Fee Screen

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Policy Overview

Medical Clearance

Medicaid requires a medical evaluation to be performed by a physician, physician assistant, or advanced practice registered nurse within six months prior to the beneficiary obtaining a hearing aid.

Dispensing Fee

Medicaid reimbursement of a Hearing Aid Dispensing Fee covers all services and products listed below for a period of 90 days unless otherwise noted Per the MI Medicaid Provider Manual, Chapter Hearing Services and Devices, Section 4.8:

- Hearing aid delivery
- Adjustments required within the manufacturer's warranty period
- Fitting, orientation, and checking of the hearing aid
- Instructions on use and care of the hearing aid
- Initial earmolds and impressions
- Necessary components that may include cords, tubing, connectors, receivers, and huggies
- One 90-day supply of batteries per aid
- A 90-day trial/adjustment period with exchange/return privilege.

General Billing Resources

www.Michigan.gov/MedicaidProviders >> CHAMPS

- Medicaid Code and Rate Reference Tool
- Provider Verification Tool
- Prior Authorization
- Medicaid Hearing Services/Hearing Aid Dealers Fee Screen
- Verifying Member Eligibility
- Claim Submission
- Claim Inquiry
- Claim Limit List

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Medicaid Code and Rate Reference Tool

The Medicaid Code and Rate Reference tool is used for providers to view code details such as rates, limits, age restrictions, gender restrictions, modifier requirements, and prior authorization requirements.

- CHAMPS 102 Medicaid Code and Rate Reference Tool - Video
- Medicaid Code and Rate Reference Tool Quick Reference Guide - PDF
- Medicaid Code and Rate Reference Tutorial – PDF, Webinar

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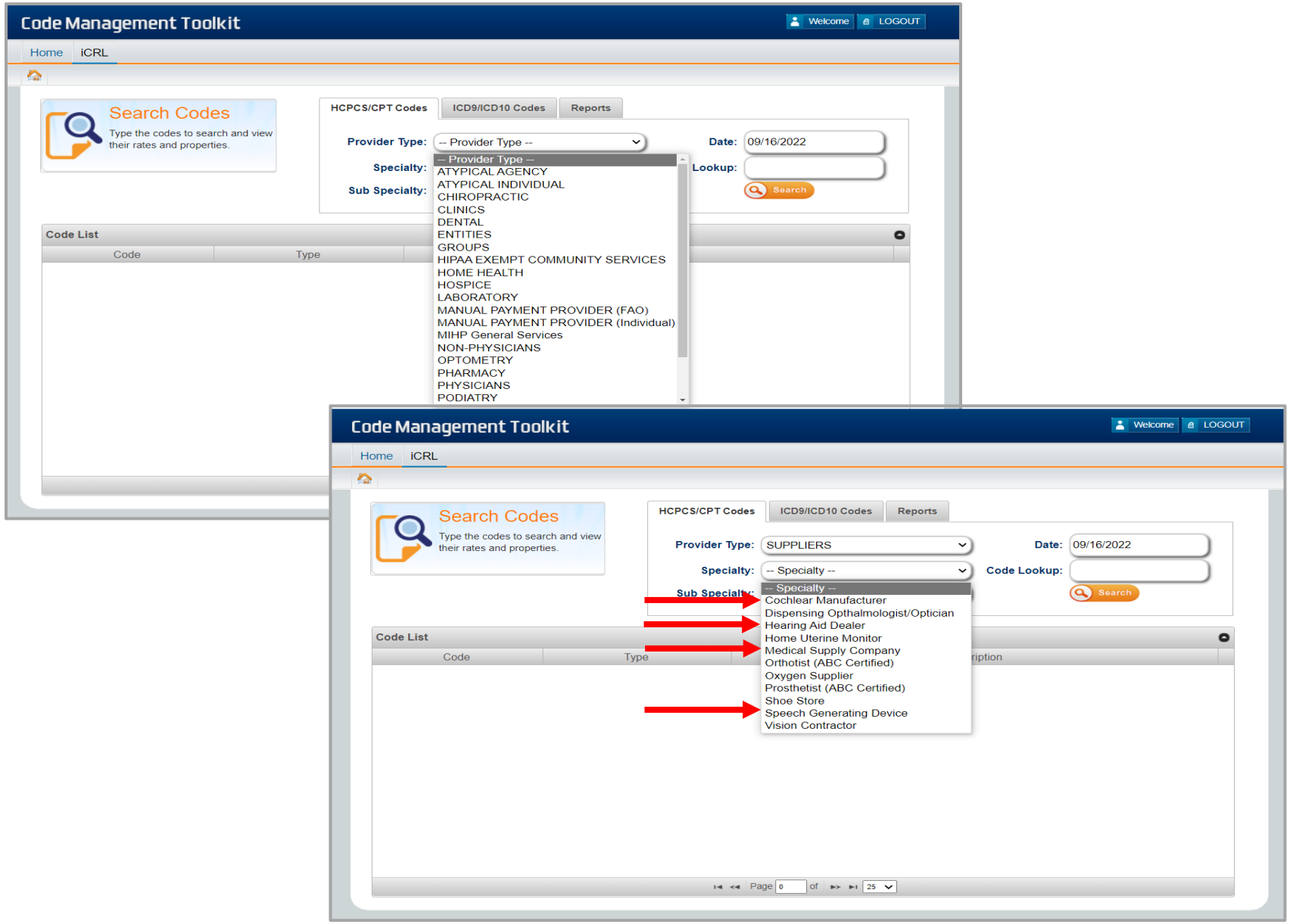
Medicaid Code and Rate Reference Tool

- This tool can be accessed from the External Links dropdown within CHAMPS.
- Once on the main screen, select the appropriate provider type then, the specialty.
- Update the prepopulated date if looking to verify a date other than the current.
- Enter the code to look up
- Click on the Search button and the code will display as a blue hyperlink under the Code List Section.



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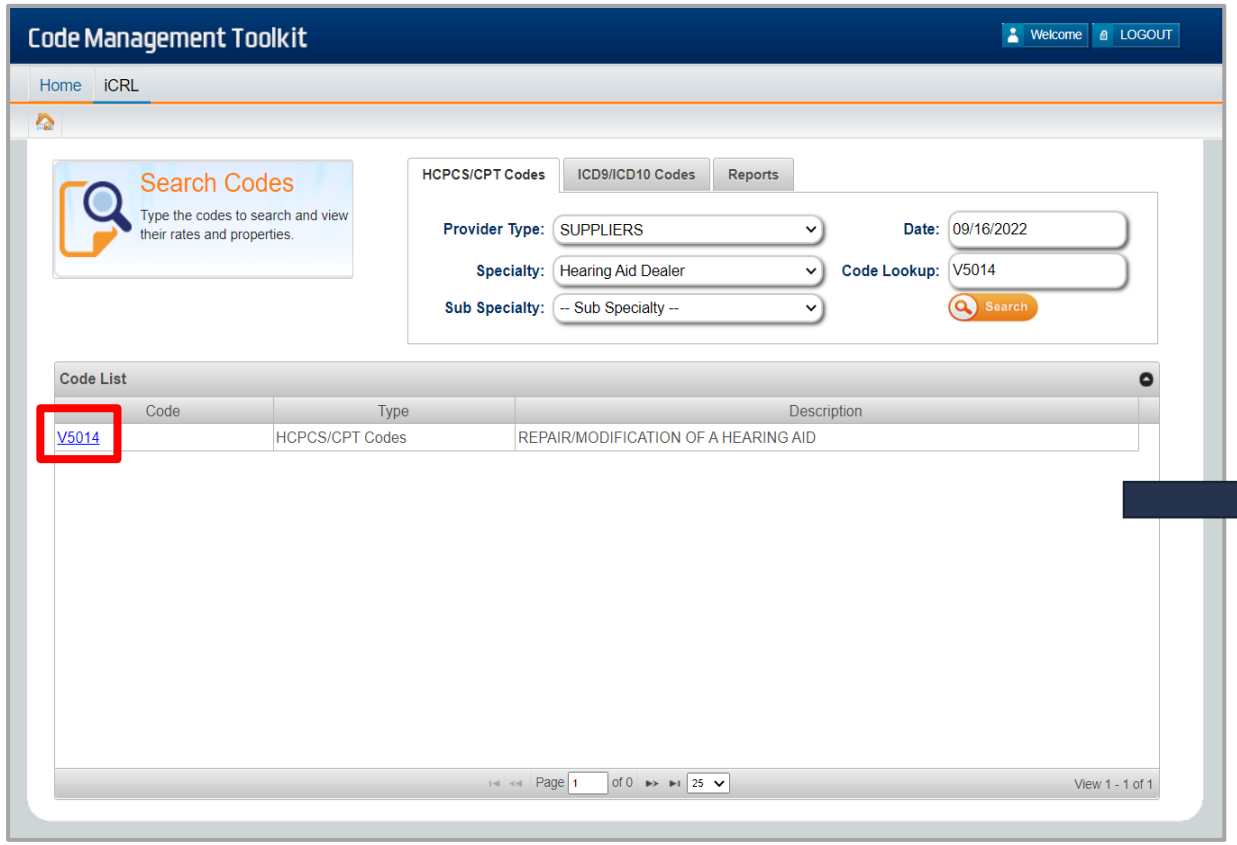

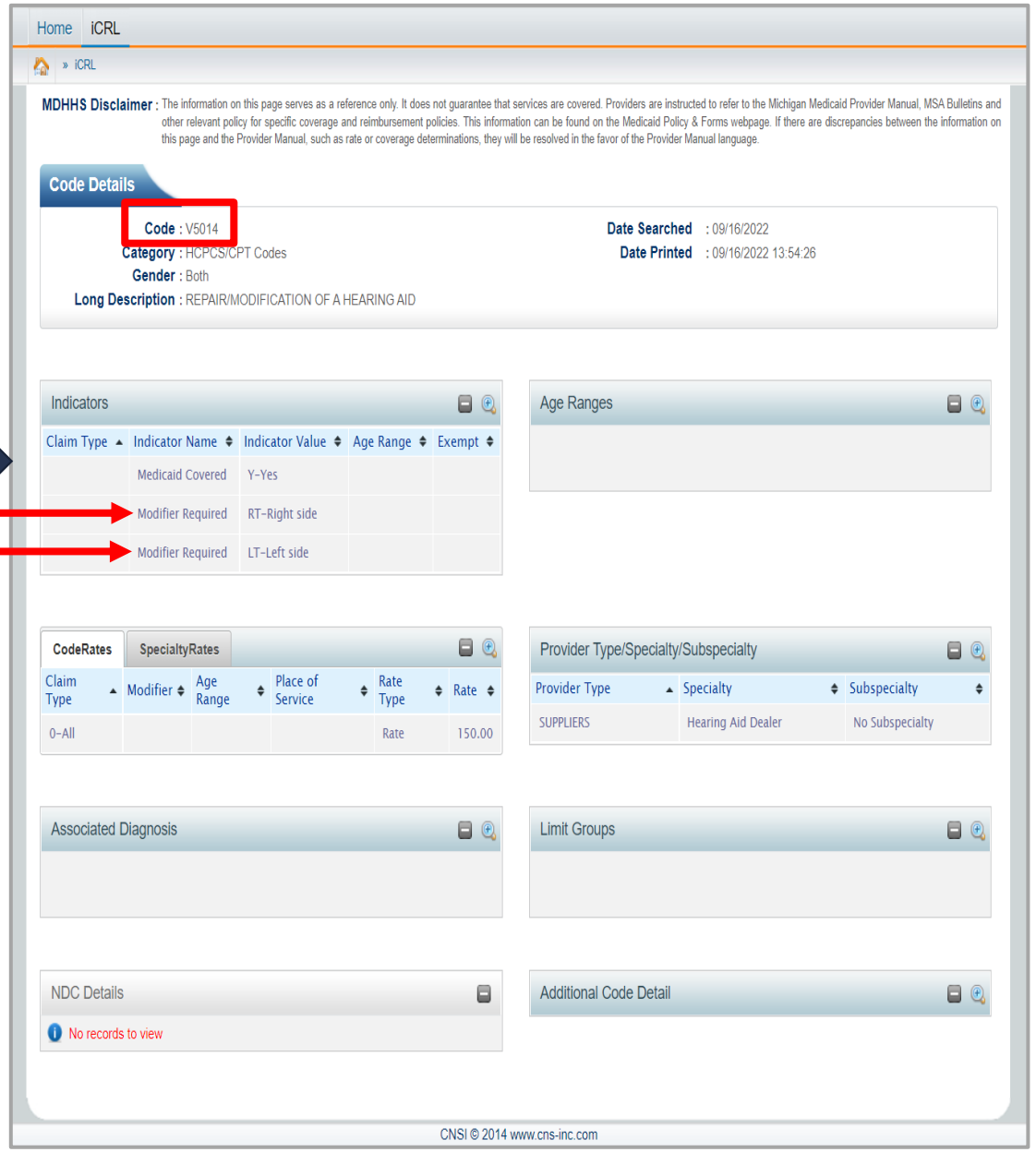

After selecting the blue hyperlink from the code list the code details will display to give additional code restriction details.

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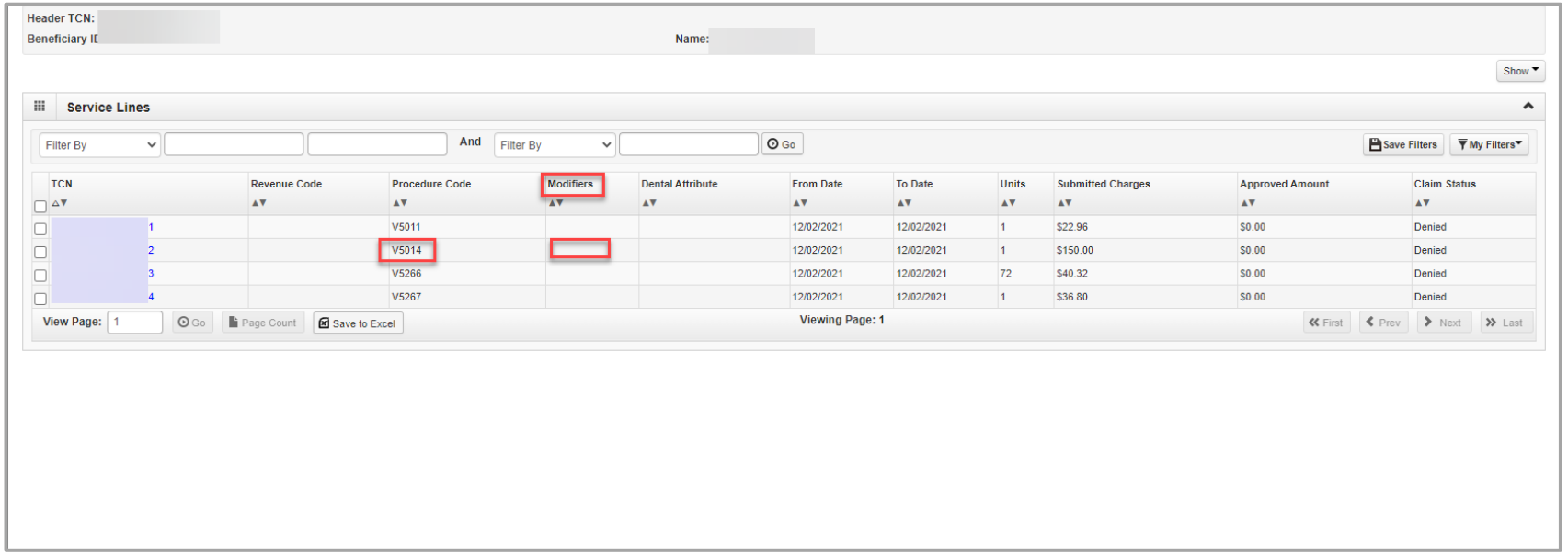
Medicaid Code and Rate Reference Tool

- Claim was billed and claim line was denied for missing the required modifier(s).
- Common procedures that require an RT or LT modifier - Monaural Hearing Aid Devices, Ear Molds, and Device Repairs.



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Provider Verification Tool

The CHAMPS Provider Verification Tool is available for providers to verify if any provider is enrolled with Michigan Medicaid. Any individual or entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the Medicaid State Plan is required to be screened and enrolled in Medicaid.

- CHAMPS 101: My Inbox Tab - PDF
- Provider Verification Tool Quick Reference Guide - PDF

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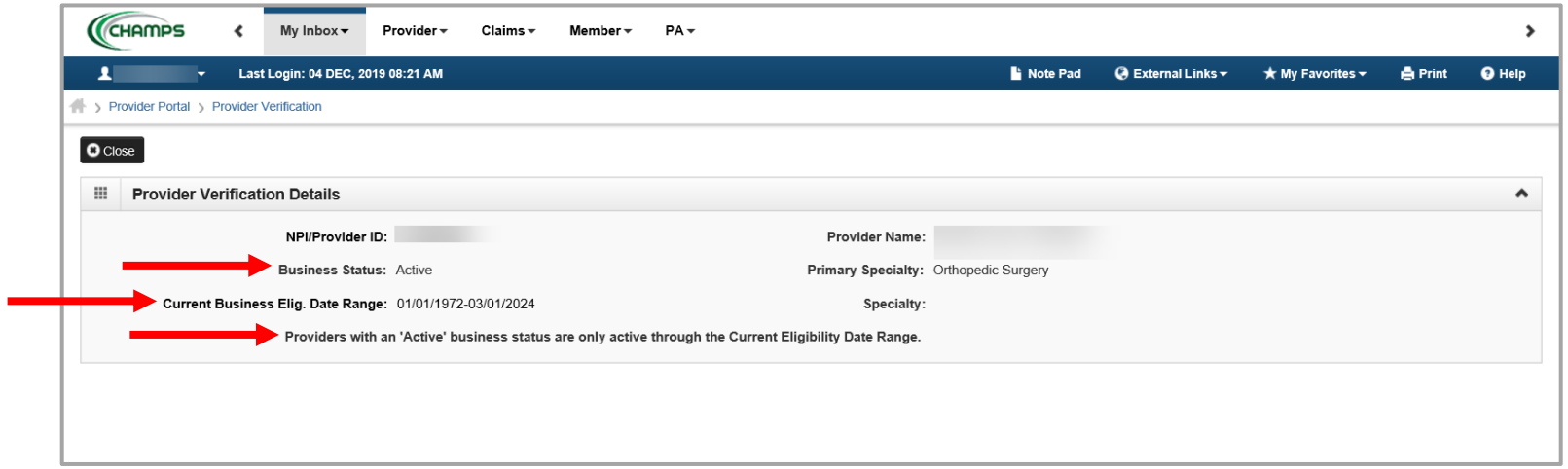
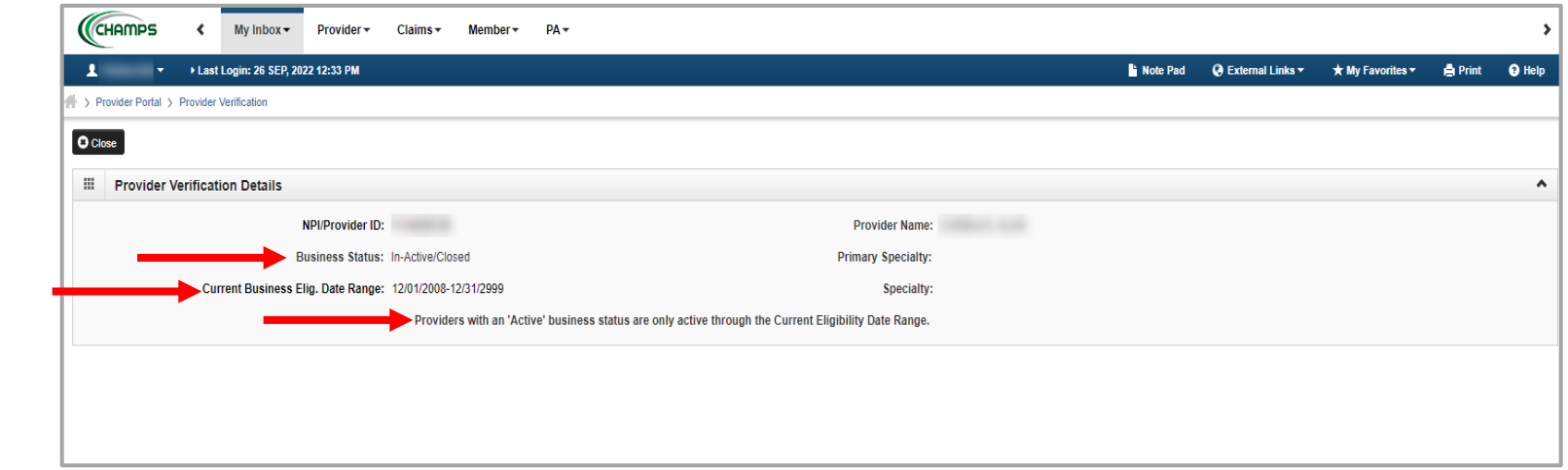
Provider Verification Tool

- The Provider Verification Details screen will display the provider information, take note of the business status:
- Active: The provider NPI or ID is enrolled with Michigan Medicaid.
- Providers with an 'Active' business status are only active through the Current Business Eligibility Date Range.
- Inactive: The provider NPI or ID was at one time enrolled with Michigan Medicaid and is no longer active, the provider should contact Provider Enrollment.
- Deceased: The provider NPI or ID has a date of death on file.
- If the NPI/Provider ID is not enrolled within CHAMPS providers will receive an error that reads "NPI/Provider ID entered does not exist within the system."





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Prior Authorization

Prior Authorization (PA) is required for certain services before the services are rendered. To determine which service requires PA, refer to the prior authorization subsections throughout this chapter and the Medicaid Code and Rate Reference tool.

- PA Overview – PDF, Webinar
- PA Quick Reference Guide - PDF
- CHAMPS 102 PA Submission – Video
- CHAMPS 102 PA Inquiry – Video

Prior Authorization

PA is Required

Per the MI Medicaid Provider Manual, Chapter Hearing Services and Devices, Section 3 & 5:

- Services or devices for which the beneficiary does not meet the Medicaid Standards of Coverage as outlined in policy
- Any hearing aids that are not covered under the MDHHS volume purchase contract
- Alternative Listening Devices (ALDs)
- Cochlear implant devices or processors (unilateral or bilateral)
- Bone Anchored Hearing Device (BAHDs) or processors (bilateral only)
- Services and items that exceed quantity limits, or established fee screens
- Use of not otherwise classified (NOC) codes

PA is NOT Required

Per the MI Medicaid Provider Manual, Chapter Hearing Services and Devices, Section 5:

- Any hearing aid device selected from the Hearing Aid Volume Purchase Contract Model Listing up to 1 per 5 years
- Any hearing aid dispensing fees up to 1 per 5 years
- Any ear molds unless more than 4 are dispensed per 12 months for children under 3 years, more than 2 are dispensed per 12 months for ages 3-21 years old, or more than 1 is dispensed per 12 months for ages 21 years and older
- Hearing aid checks/programming/fitting services rendered 90 days after a hearing aid device is dispensed-up to 2 per year

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Medicaid Hearing Services/Hearing Aid Dealers Fee Screens

Visit fee screens to review procedure codes, and other billing and reimbursement information for services covered by the following programs: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), MIChild, Maternity Outpatient Medical Services (MOMS), and other health care programs administered by MDHHS. The information on these pages serves as a reference only. It does not guarantee that services are covered.

- Hearing Services / Hearing Aid Dealers Fee Screen Link - Website

MDHHS Michigan Department of Health & Human Services

Hearing Services and Devices

MDHHS > Doing Business with MDHHS > Health Care Providers > Providers > Billling and Reimbursement > Hearing Services and Devices

Hearing Aid Dealers Database

Choose an option

View Report

Hearing Services Fee Databases

Choose an option

View Report

For additional pertinent coverage parameters which is accessible via the External Links m real-time information for the following:

- Age restrictions,
- Diagnoses allowable for Ambulance,
- Documentation requirements,
- Frequency limitations,
- Hospital discharge - Bypass PA
- NDC information,
- Prior authorizations and medical conditi
- Rate information,
- Required modifiers,
- Supplies/DME - per diem, and
- Tooth number and surface requirements.

To request or view upcoming training sessions please refer to the Michigan Department of Health and Human Services website at www.michigan.gov/medicaidproviders>>Training>>Medicaid Provider Trainings.

Any questions should be directed to Provider Inquiry, Michigan Department of Health and Human Services, phone toll-free 1-800-292-2550 or email at providersupport@michigan.gov.

Hearing Services and Devices New Provider and Policy Updates PDF Webinar

Hearing Aid Contract Models

Hearing Aid Contract Vendor Contact List

Hearing Aid Supplies and Accessories

Cochlear Implant Replacement Parts and Accessories

Bone Anchored Hearing Device Replacement Parts and Accessories

Fee Screens: Providers can download fee screens in PDF or Microsoft Excel format.

- First, select the format from the "Choose an option"
- Second, click on "View Report"

MDHHS
Hearing Aid Dealers Database
September 2022

HCPCS Code	Mod	Short Description	Maximum Fee	Limits	PA	Comments
V5011		Hearing Aid Fitting/Checking	$22.96	2 per Year		
V5014*	LT/RT	Hearing Aid Repair/Modifying	$150.00*	2 per Year	N*	
V5020		Conformity Evaluation	$35.75	2 per Year		
V5030	LT/RT	Body-Worn Hearing Aid Air	$450.00	1 per 5 Years	Y	
V5040	LT/RT	Body-Worn Hearing Aid Bone	$450.00	1 per 5 Years	Y	
V5050	LT/RT	Hearing Aid Monaural In Ear	$450.00	1 per 5 Years	Y	
V5060	LT/RT	Behind Ear Hearing Aid	$450.00	1 per 5 Years	Y	
V5100		Body-Worn Bilat Hearing Aid	$900.00	1 per 5 Years	Y	
V5110		Hearing Aid Dispensing Fee	$336.32	1 per 5 Years		
V5120		Body-Worn Binaur Hearing Aid	$900.00	1 per 5 Years	Y	
V5130		In Ear				
V5140		Behin				
V5160		Dispe				
V5171	LT/RT	Hearir				
V5172	LT/RT	Hearir				
V5181	LT/RT	Hearir				
V5200		Disp F				
V5211		Hearir				
V5212		Hearir				
V5213		Hearir				
V5214		Hearir				
V5215		Hearir				
V5221		Hearir				
V5240		Disp F				
V5241	LT/RT	Dispe				
V5242	LT/RT	Hearir				
V5243	LT/RT	Hearir				
V5244	LT/RT	Hearir				
V5245	LT/RT	Hearir				
V5246	LT/RT	Hearir				

CPT codes, descriptio and tw

The information on this page se to refer to the Michigan Medica reimbursement policies. This inf discrepancies between the infor they will be resolved in favor of

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Internal Data (Standard State Data)

	A	B	C	D	E	F	G
1	HCPCS Code	Mod	Short Description	Maximum Fee	Limits	PA	Comments
2	V5011		Hearing Aid Fitting/Checking	$22.96	2 per Year		
3	V5014*	LT/RT	Hearing Aid Repair/Modifying	$150.00*	2 per Year	N*	
4	V5020		Conformity Evaluation	$35.75	2 per Year		
5	V5030	LT/RT	Body-Worn Hearing Aid Air	$450.00	1 per 5 Years	Y	
6	V5040	LT/RT	Body-Worn Hearing Aid Bone	$450.00	1 per 5 Years	Y	
7	V5050	LT/RT	Hearing Aid Monaural In Ear	$450.00	1 per 5 Years	Y	
8	V5060	LT/RT	Behind Ear Hearing Aid	$450.00	1 per 5 Years	Y	
9	V5100		Body-Worn Bilat Hearing Aid	$900.00	1 per 5 Years	Y	
10	V5110		Hearing Aid Dispensing Fee	$336.32	1 per 5 Years		
11	V5120		Body-Worn Binaur Hearing Aid	$900.00	1 per 5 Years	Y	
12	V5130		In Ear Binaural Hearing Aid	$900.00	1 per 5 Years	Y	
13	V5140		Behind Ear Binaur Hearing Ai	$900.00	1 per 5 Years	Y	
14	V5160		Dispensing Fee Binaural	$336.32	1 per 5 Years		
15	V5171	LT/RT	Hearing Aid Monaural Ite	See Contract	1 per 5 Years		
16	V5172	LT/RT	Hearing Aid Monaural Itc	$900.00	1 per 5 Years	Y	
17	V5181	LT/RT	Hearing Aid Monaural Bte	See Contract	1 per 5 Years		
18	V5200		Disp Fee Contralateral Monau	$195.37	1 per 5 Years		
19	V5211		Hearing Aid Binaural Ite/Ite	See Contract	1 per 5 Years		
20	V5212		Hearing Aid Binaural Ite/Itc	$900.00	1 per 5 Years	Y	
21	V5213		Hearing Aid Binaural Ite/Bte	$900.00	1 per 5 Years	Y	
22	V5214		Hearing Aid Binaural Itc/Itc	$900.00	1 per 5 Years	Y	
23	V5215		Hearing Aid Binaural Itc/Bte	$900.00	1 per 5 Years	Y	
24	V5221		Hearing Aid Binaural Bte/Bte	See Contract	1 per 5 Years		
25	V5240		Disp Fee Contralateral Binau	$336.32	1 per 5 Years		
26	V5241	LT/RT	Dispensing Fee, Monaural	$195.37	1 per 5 Years		
27	V5242	LT/RT	Hearing Aid, Monaural, Cic	$450.00	1 per 5 Years	Y	
28	V5243	LT/RT	Hearing Aid, Monaural, Itc	$450.00	1 per 5 Years	Y	
29	V5244	LT/RT	Hearing Aid, Prog, Mon, Cic	$450.00	1 per 5 Years	Y	
30	V5245	LT/RT	Hearing Aid, Prog, Mon, Itc	$450.00	1 per 5 Years	Y	
31	V5246	LT/RT	Hearing Aid, Prog, Mon, Ite	$450.00	1 per 5 Years	Y	
32	V5247	LT/RT	Hearing Aid, Prog, Mon, Bte	$450.00	1 per 5 Years	Y	
33	V5248		Hearing Aid, Binaural, Cic	$900.00	1 per 5 Years	Y	
34	V5249		Hearing Aid, Binaural, Itc	$900.00	1 per 5 Years	Y	
35	V5250		Hearing Aid, Prog, Bin, Cic	$900.00	1 per 5 Years	Y	

Hearing Aid Dealers

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Verifying Member Eligibility

A person eligible for and/or who receives services under the MI Medicaid Program can be verified by using the member search function. The Member tab or function in CHAMPS allows access for users to verify eligibility for a member via the web-based screens or by submitting a 270-electronic request. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific date of service.

- Member Tab Overview – PDF, Webinar
- Eligibility Quick Reference – PDF
- CHAMPS 102 Member Eligibility - Video

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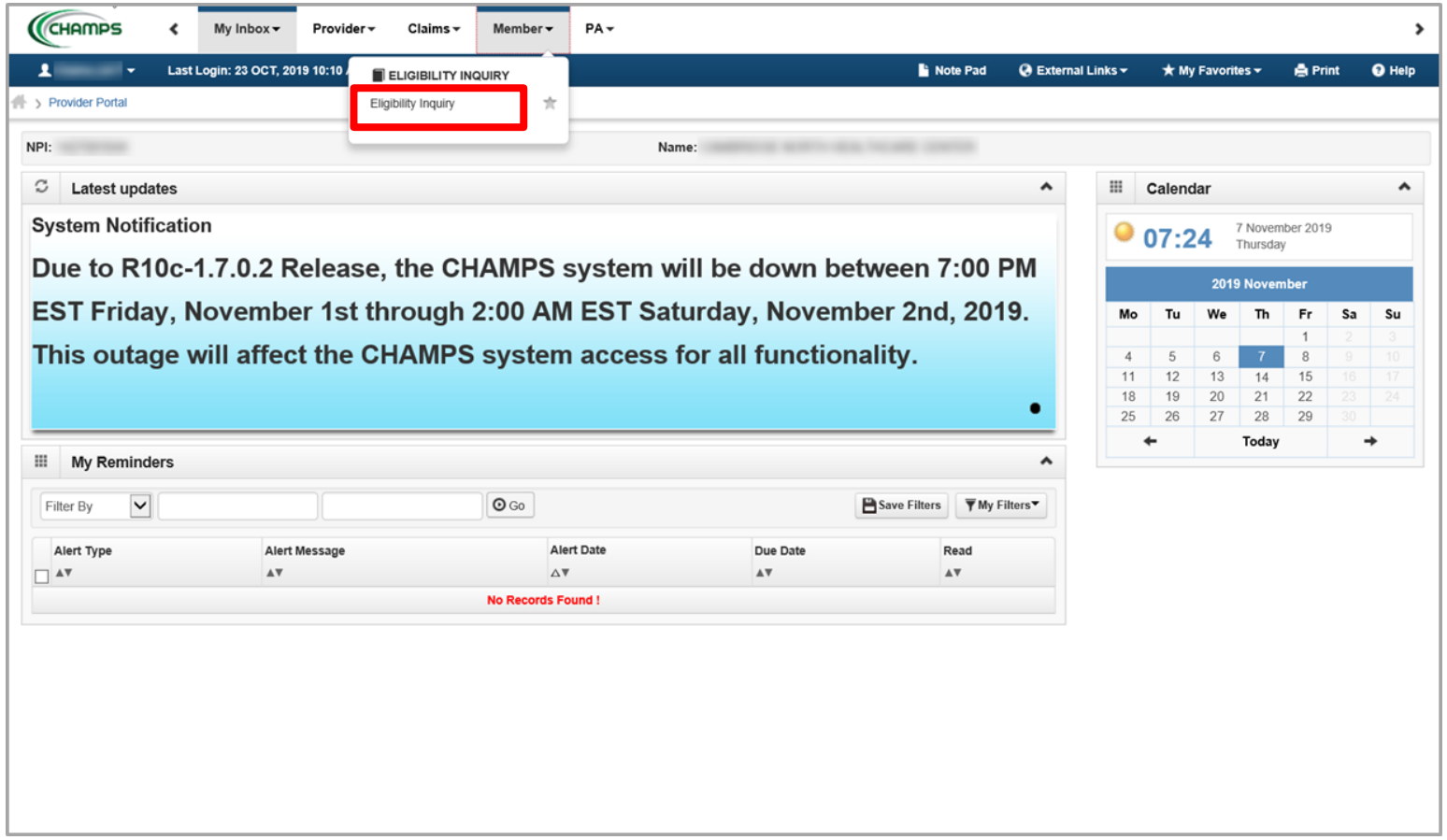
Eligibility Inquiry Resources

- Options for verifying beneficiary eligibility include:
  - CHAMPS Eligibility Inquiry
  - HIPAA 270/271 (Eligibility Inquiry/Response) transactions
  - Web-based options
- Click on Eligibility Inquiry from the Member tab.



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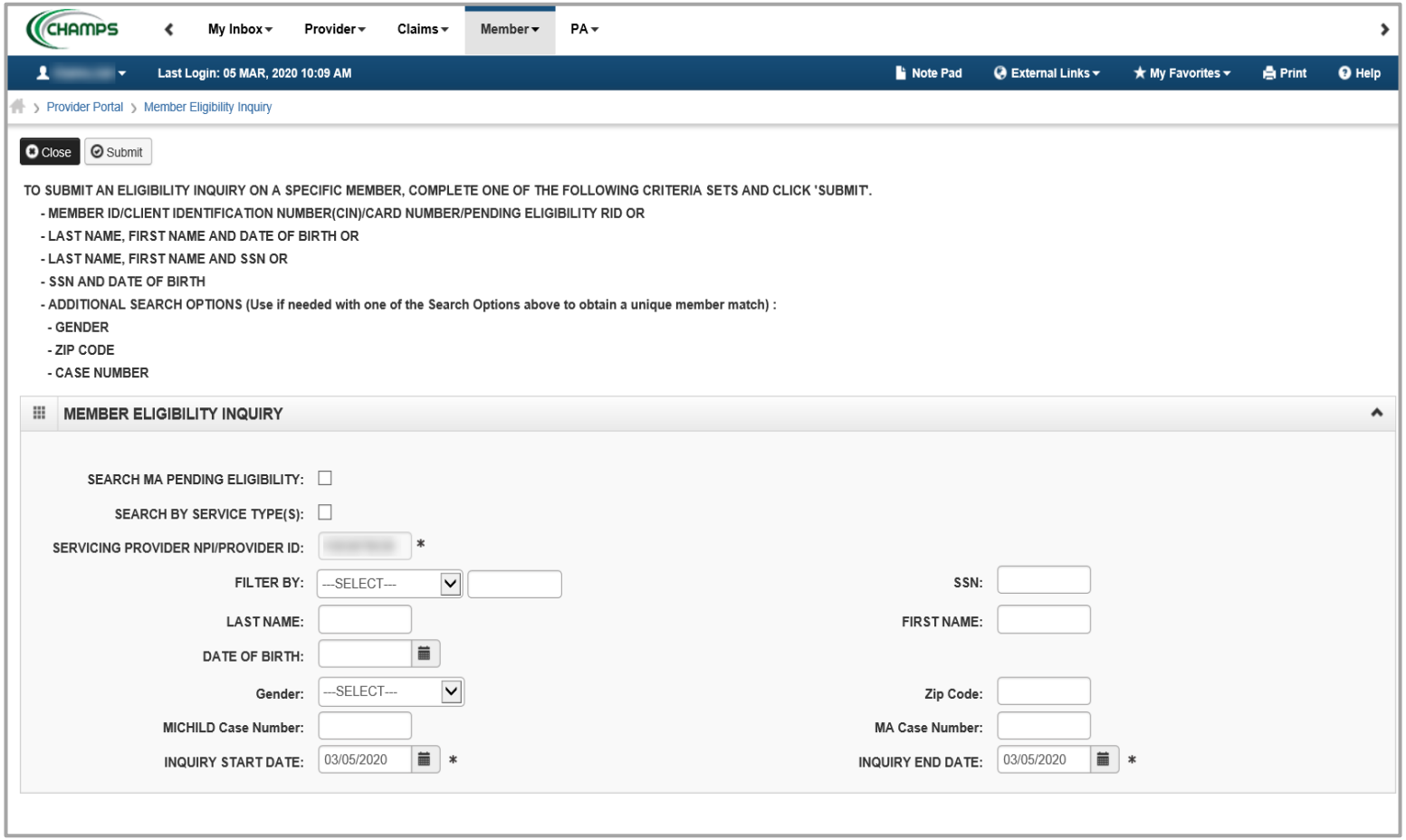
Verifying Eligibility

- If a beneficiary does not have a mihealth card, a provider can also access the beneficiary's eligibility information with the additional search methods displayed.
- For a list of each of the Benefit Plans and their description visit the Michigan Medicaid Provider Manual>>reference Chapter Beneficiary Eligibility>>Section 2.1 Benefit Plans
- For further help in understanding the Member Eligibility Screen reference Eligibility Inquiry resource from www.Michigan.gov/MedicaidProviders>>CHAMPS>>Eligibility and Enrollment (Member Tab)



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Verifying Eligibility: CSHCS

- Michigan Medicaid Provider Manual
  - Children's Special Health Care Services Website
  - CSHCS Non-Authorized Provider Rules
  - Local Health Department Contact List – To get provider authorization

Children's Special Health Care Services (CSHCS)

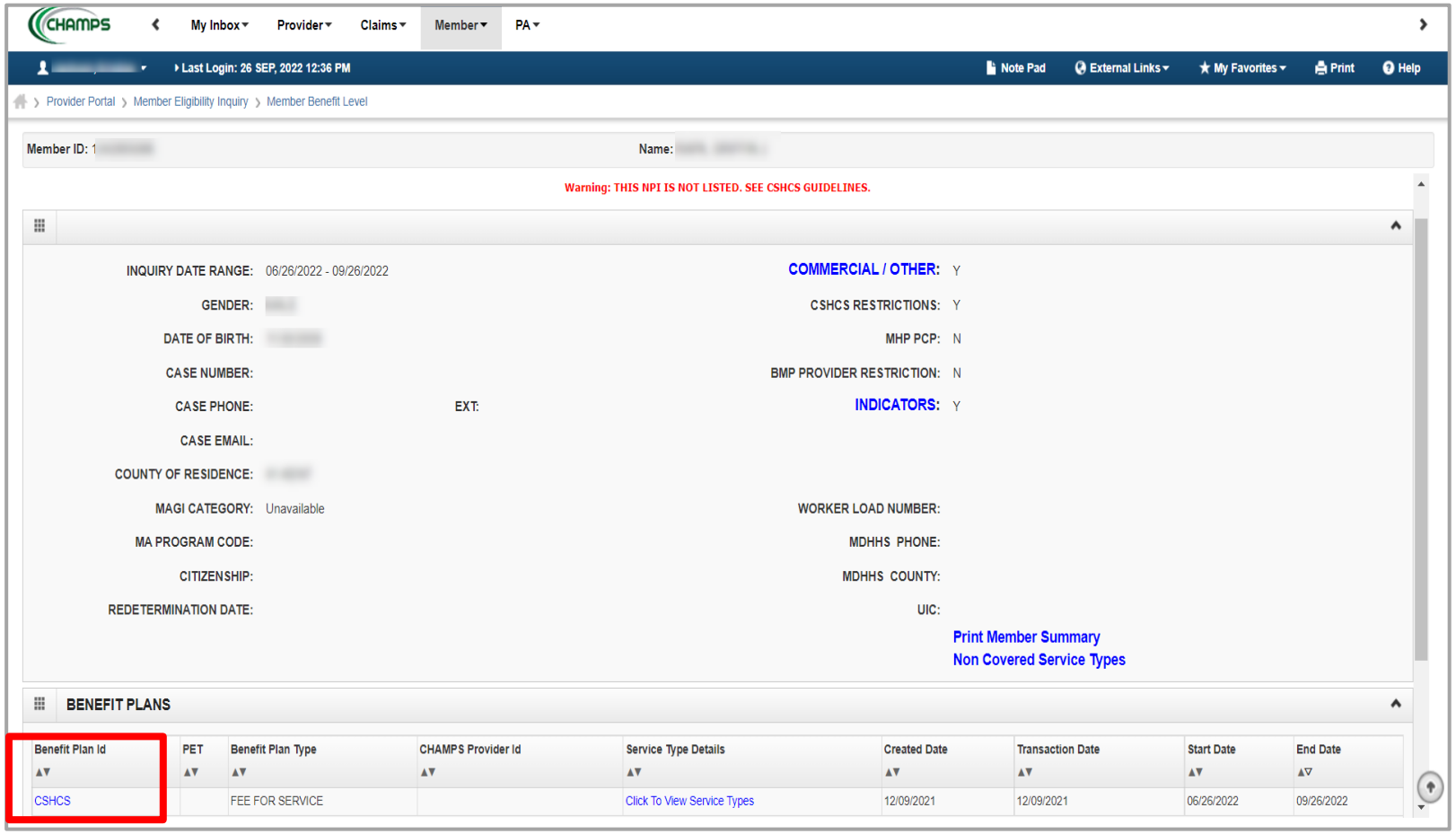
A pediatric subspecialist is authorized by CSHCS to serve the beneficiary. They coordinate hearing treatment and services. Before billing for audiology services, the enrolled provider(s) must verify that they have been authorized to provide services to the beneficiary.

How do I know if the ordering or prescribing provider is an authorized provider for CHSCS?

- Authorized provider and diagnosis information can be obtained from the beneficiary's Client Eligibility Notice.
- The CHAMPS Eligibility Inquiry and/or HIPAA 270/271 transaction will also indicate if the inquiring provider NPI number is authorized to render CSHCS services for the beneficiary on that date of service.
  - Providers will receive the Benefit Plan ID of CSHCS along with one of the following messages in the eligibility response:
    - This NPI is listed. See CSHCS guidelines list in MI Medicaid Provider Manual.
    - This NPI is not listed. See CSHCS guidelines MI Medicaid Provider Manual.

Verifying Eligibility: CSHCS

- Take note of the beneficiary's benefit plan and the start and end dates to the right. Depending on the date of service will depend on the benefit plan responsible for services.
- It's important to verify this on the date of service to confirm coverage for those services.
- Note, some benefit plan ID may show a MC along with the benefit. This means there is a health plan responsible for coverage and services should be billed to that plan.
- Also note, if the beneficiary has CSHCS the provider needs to be authorized in order to bill for services.



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Verifying Eligibility: Other Insurance

- Additional resources for verifying eligibility:
  - Adding, Removing, and Updating TPL files Instructions – PDF
  - Benefit Plan & Service Type Codes Table – PDF
  - How to Locate Payer ID and Other Health Insurance Information – Link
  - Other Insurance Type Codes- PDF

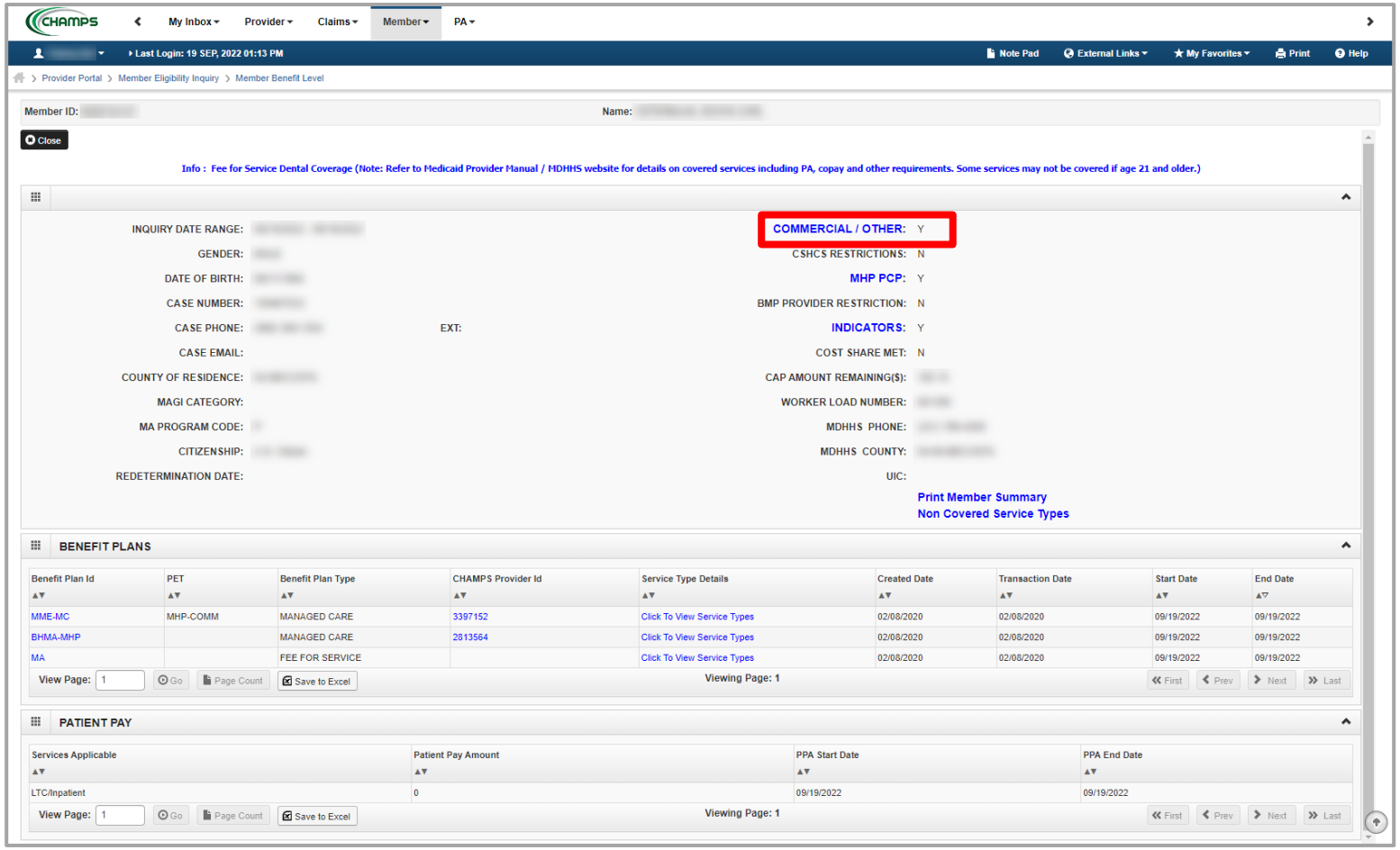
Third Party Liability

- Per the MI Medicaid Provider Manual, Chapter Coordination of Benefits, Section 1, Federal regulations require that all identifiable financial resources be utilized prior to the expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries.
- Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Health and Human Services (MDHHS).

MDHHS Michigan Department of Health & Human Services

Verifying Eligibility: Other Insurance

- If a beneficiary has a primary payer on file, the Commercial/Other field will display a Y and the Commercial/Other will become a hyperlink.
- Click the Commercial/Other hyperlink to review the primary payor on file.



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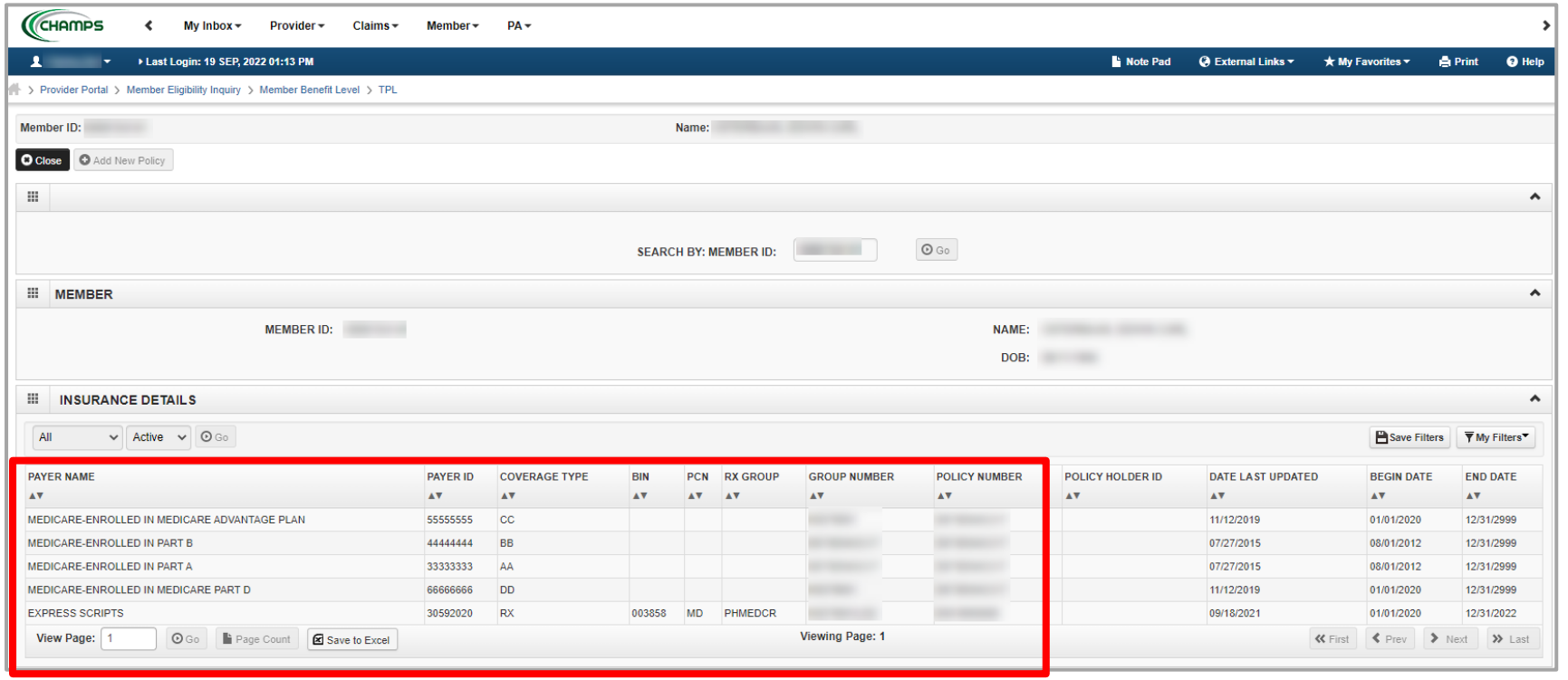
Verifying Eligibility: Other Insurance

- After selecting the Commercial/Other hyperlink the primary payer information will display.
- This includes the needed payer ID, group number, and policy number, needed for submitting a claim.
- Other Insurance Resource – PDF, Webinar
- Other Insurance Coverage Type Codes
- Insurance Coverage Request Form DCH-0078



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Claim Submission

Submitting a direct data entry (DDE) professional and Institutional claim within CHAMPS Direct Data Entry, DDE, is an online process in which data is entered into a system and written into its online files. DDE serves as an alternative method for submitting claims to Medicaid. In order to submit a claim via DDE providers must have access to CHAMPS.

- Professional DDE Quick Reference - PDF
- CHAMPS 102 Professional DDE Claim Submission - Video
- Institutional DDE Quick Reference – PDF
- CHAMPS 102 Institutional DDE Claim Submission - Video

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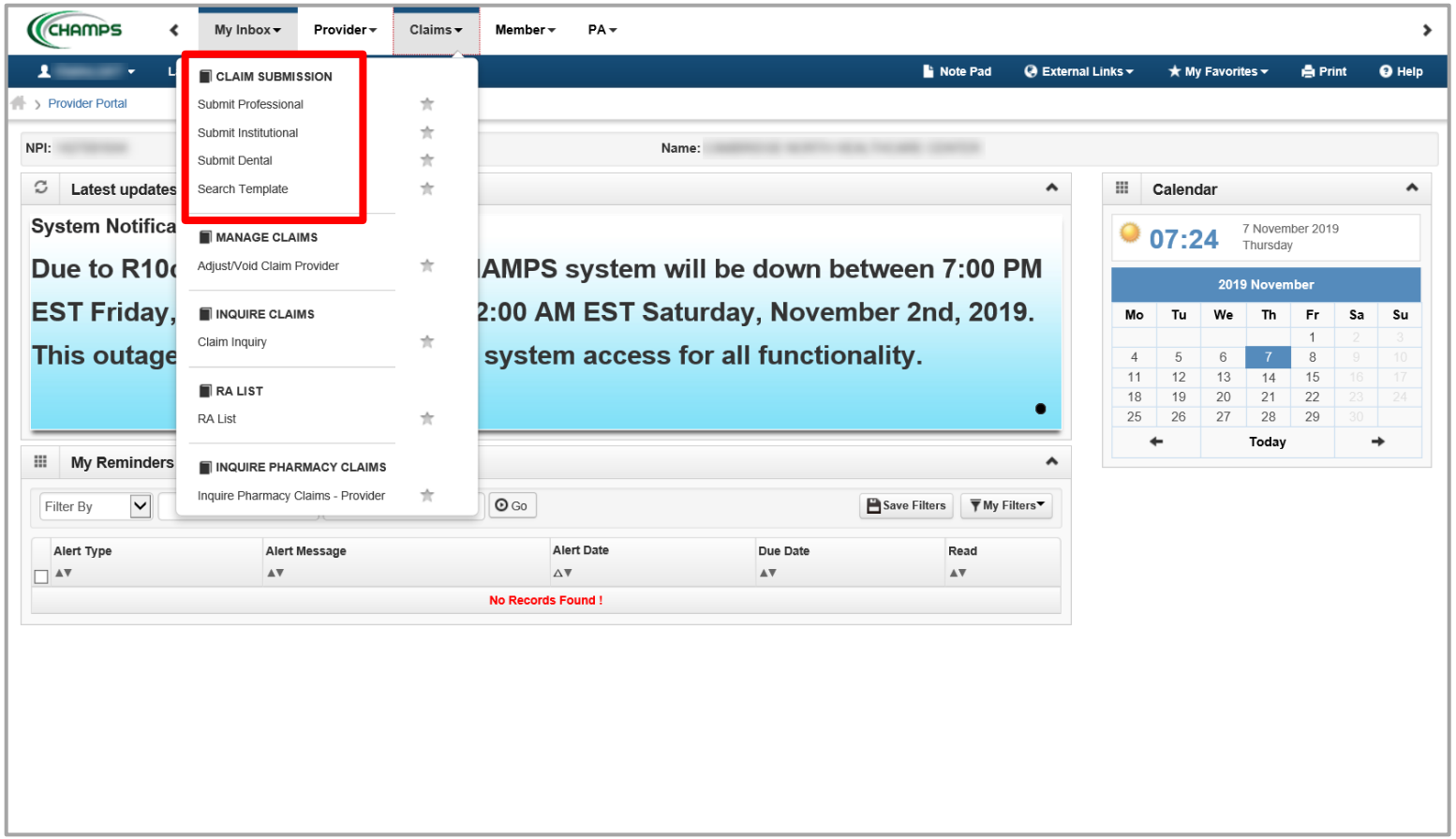
Claim Submission

- Click on any of the below hyperlinks for detailed instructions.
- CHAMPS Claims Resources
- Direct Data Entry:
  - Professional
  - Institutional
  - Search Template
- Electronic Billing:
  - Electronic Submissions Transactions
  - HIPAA – Companion Guides
  - Submitting Files Electronically



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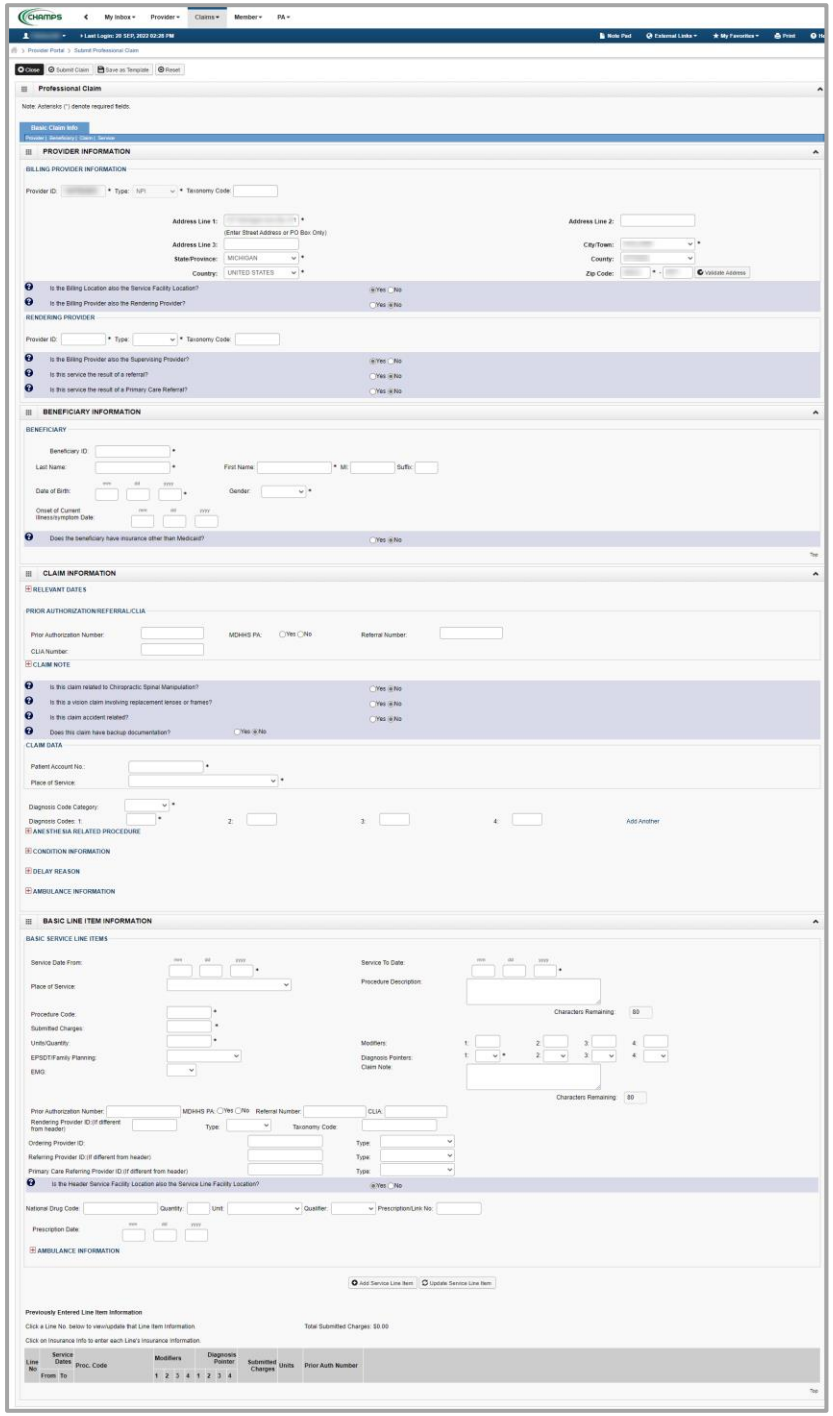
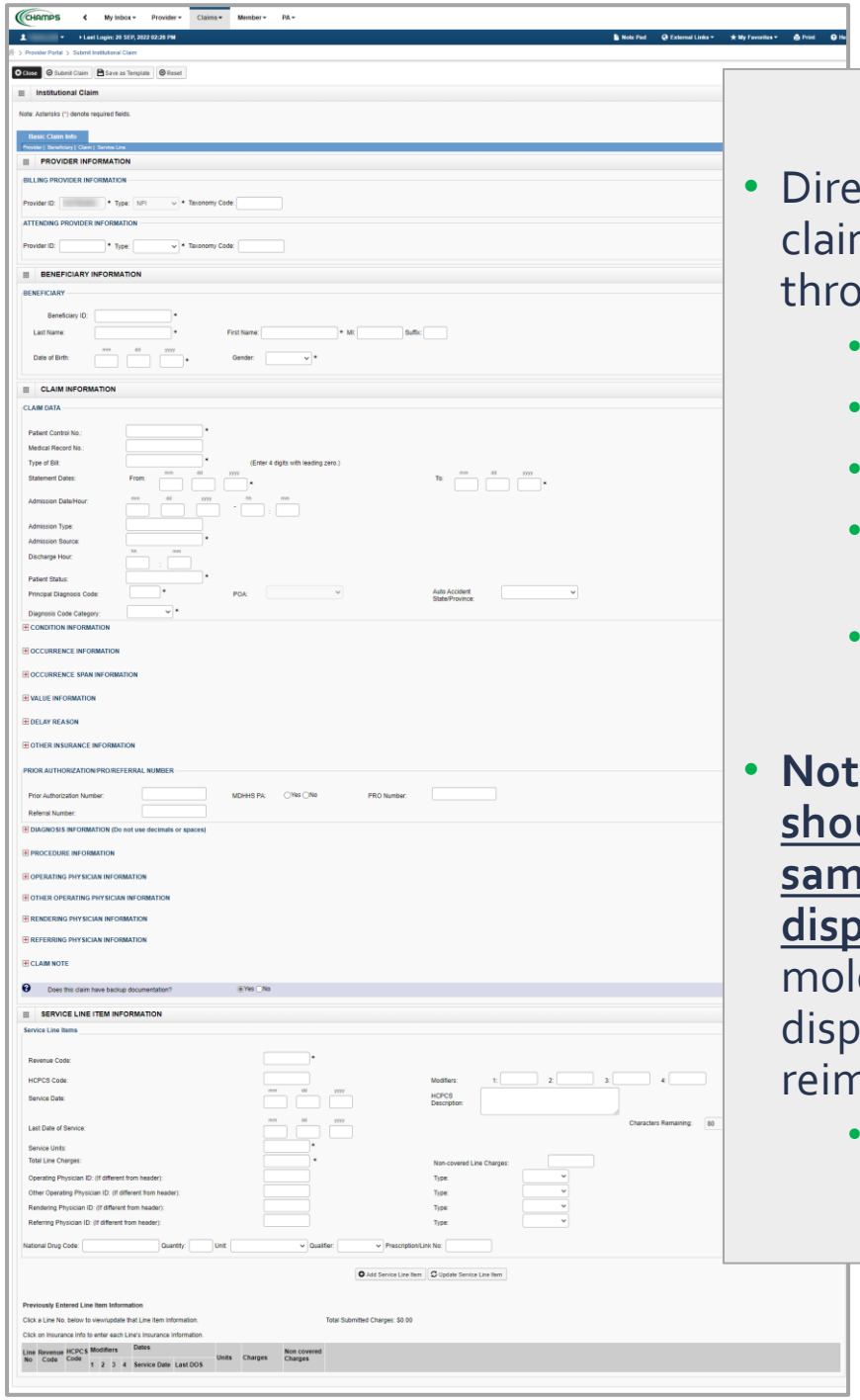




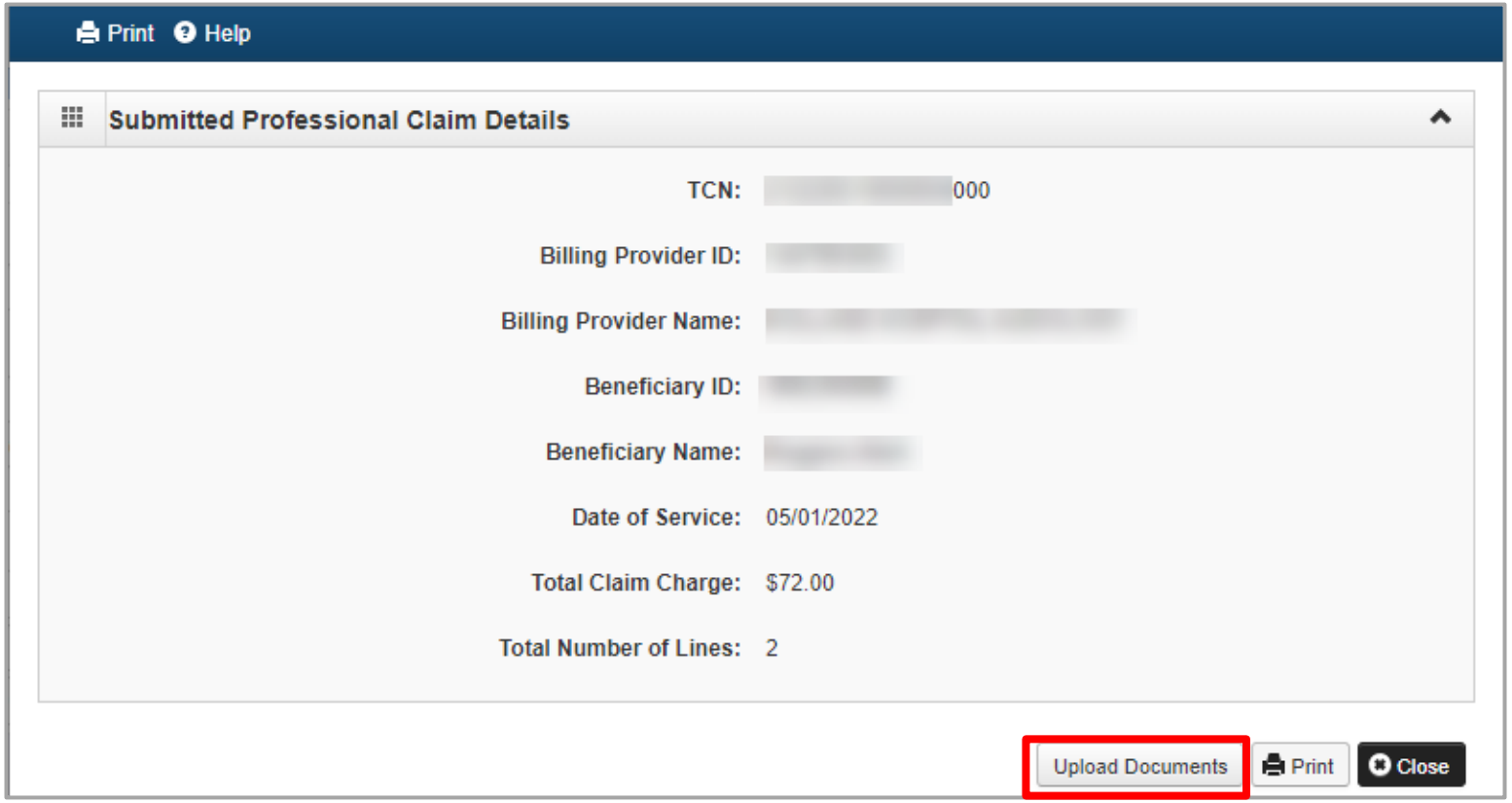
Claim Submission

- Direct Data Entry (DDE) for claims requires providers to go through the following sections:
  - Provider Information
  - Beneficiary Information
  - Claim Information
  - Professional - Basic Line Information
  - Institutional - Service Line Item Information
- **Note current policy - <u>Ear Molds should not be billed on the same date of service as the dispensing fee</u>**. Additional molds needed after the dispensing fee, can be billed and reimbursed separately.
  - Claims that have been paid incorrectly will be recouped at a later date.

MDHHS
Michigan Department of Health & Human Services

Claim Submission

- If submitting a DDE claim: After selecting submit on the claim the submitted claim details will pop up with the claim TCN and additional claim details.
- This is also where providers can utilize the Upload Documents function to upload documents into the Document Management Portal (DMP).
  - DMP Tutorial – PDF , Webinar
  - DMP for Children's Special Health Care Services (CSHCS)
  - DMP Message Function



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Claim Inquiry

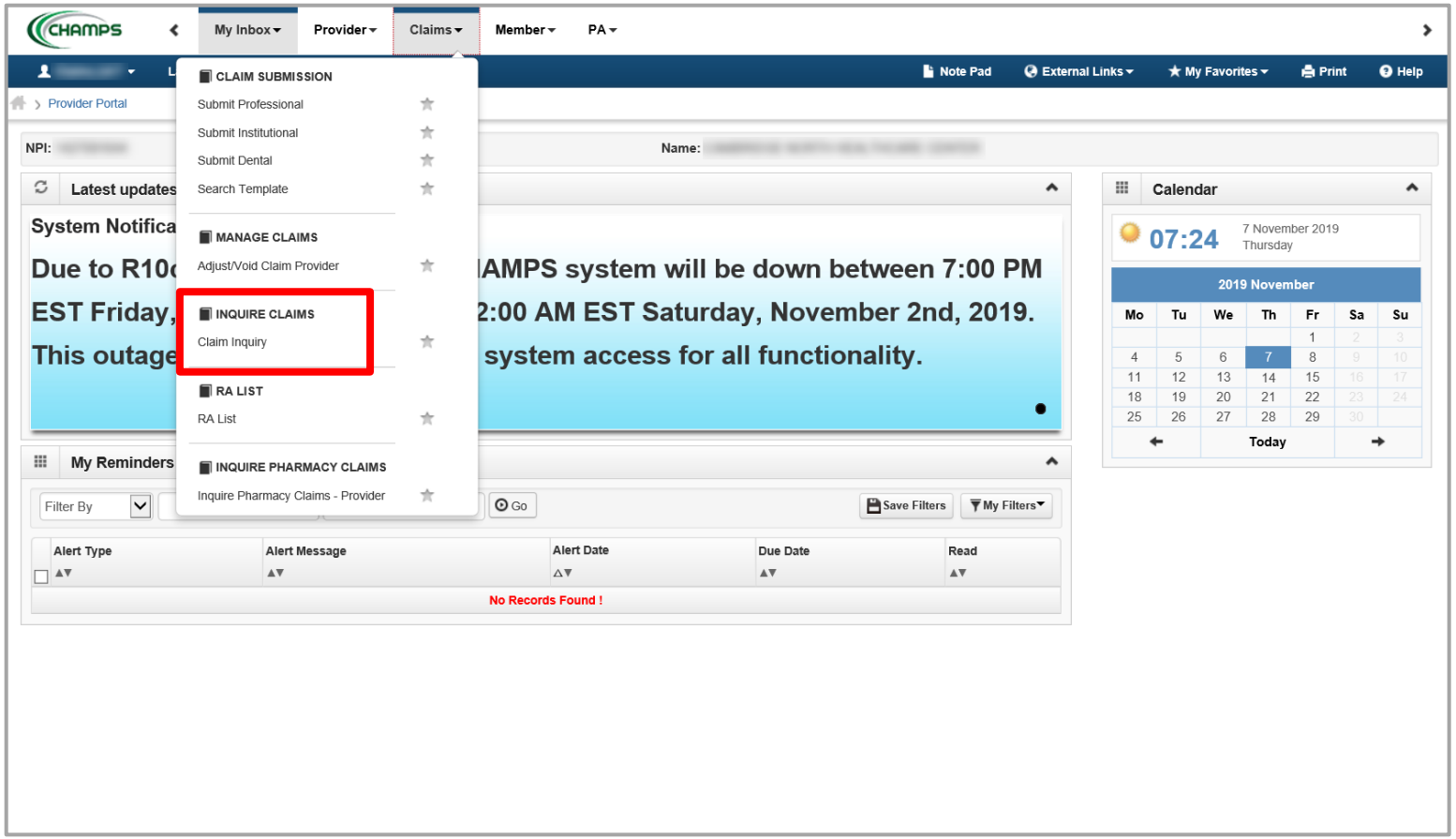
There are several different reasons for inquiring about a claim within CHAMPS. Within the Claim Inquiry section of CHAMPS, providers can utilize multiple filters to look up one claim or multiple claims.

- Claim Inquiry Quick Reference – PDF
- CHAMPS 102 Professional Claim inquiry - Video
- CHAMPS 102 Institutional Claim inquiry - Video

MDHHS Michigan Department of Health & Human Services

Claim Inquiry

- Some of the filter options for inquiring on a claim include:
  - Using a TCN to search
  - Using From/To dates to search for claims
  - Locating Reason and Remark codes
- To walk through one of the above filter options follow the Quick Reference Guide:
  - Claim Inquiry



This presentation, including screen images, is based on a CHAMPS Full Access Profile. Additional features/tabs will vary based upon profiles selected.

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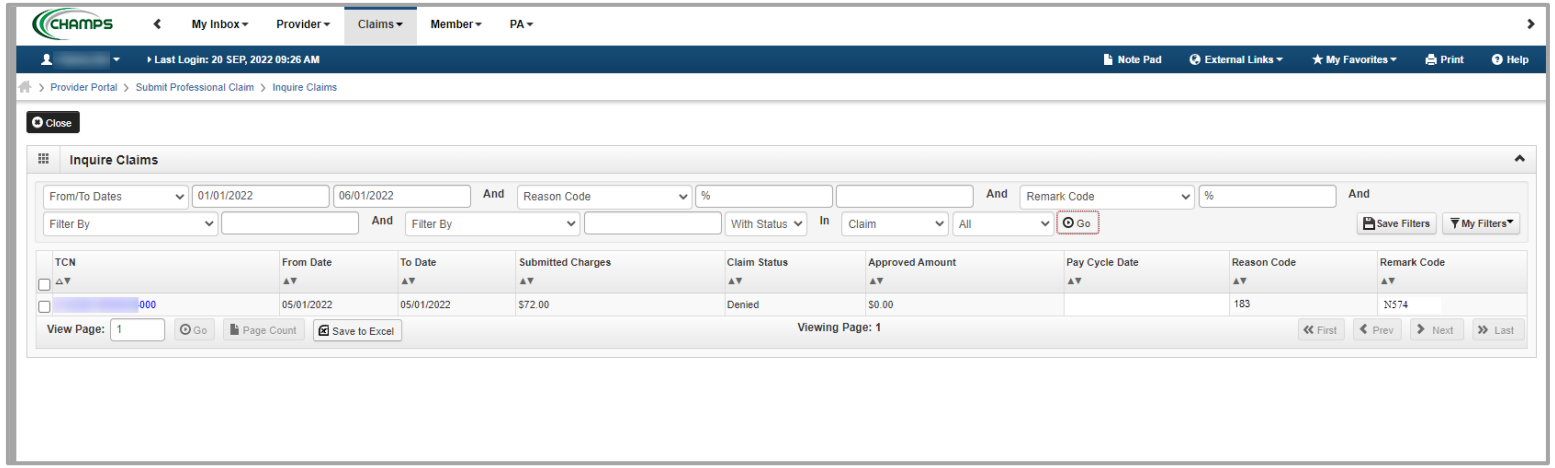
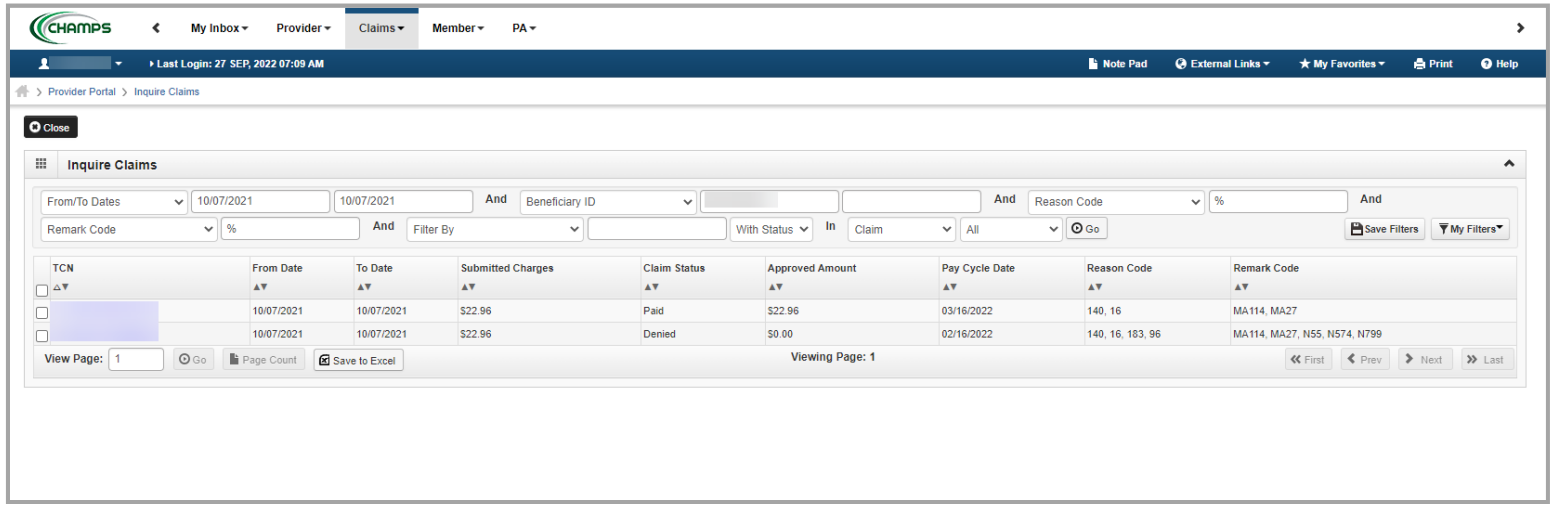
Claim Inquiry

- Professional Claim Inquiry – Video
- Institutional Claim Inquiry - Video





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Claim Limit List

Another resource for providers when utilizing claim inquiry is to utilize the Claim Limit List function. This resource will help determine the cause for a claim/service line being suspended or denied.

- Claim Limit List Quick Reference – PDF
- Claim Limit List Function - PDF

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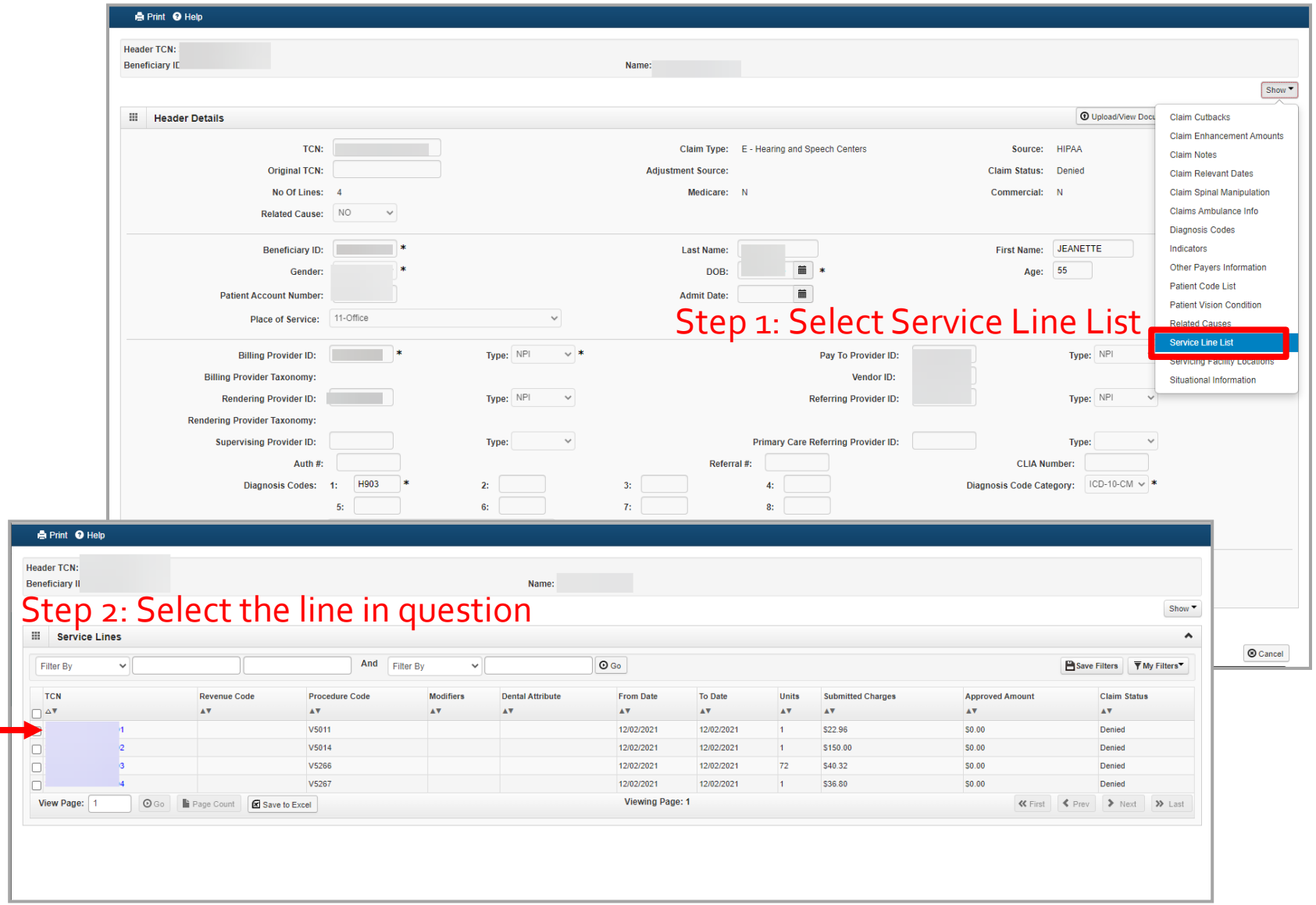
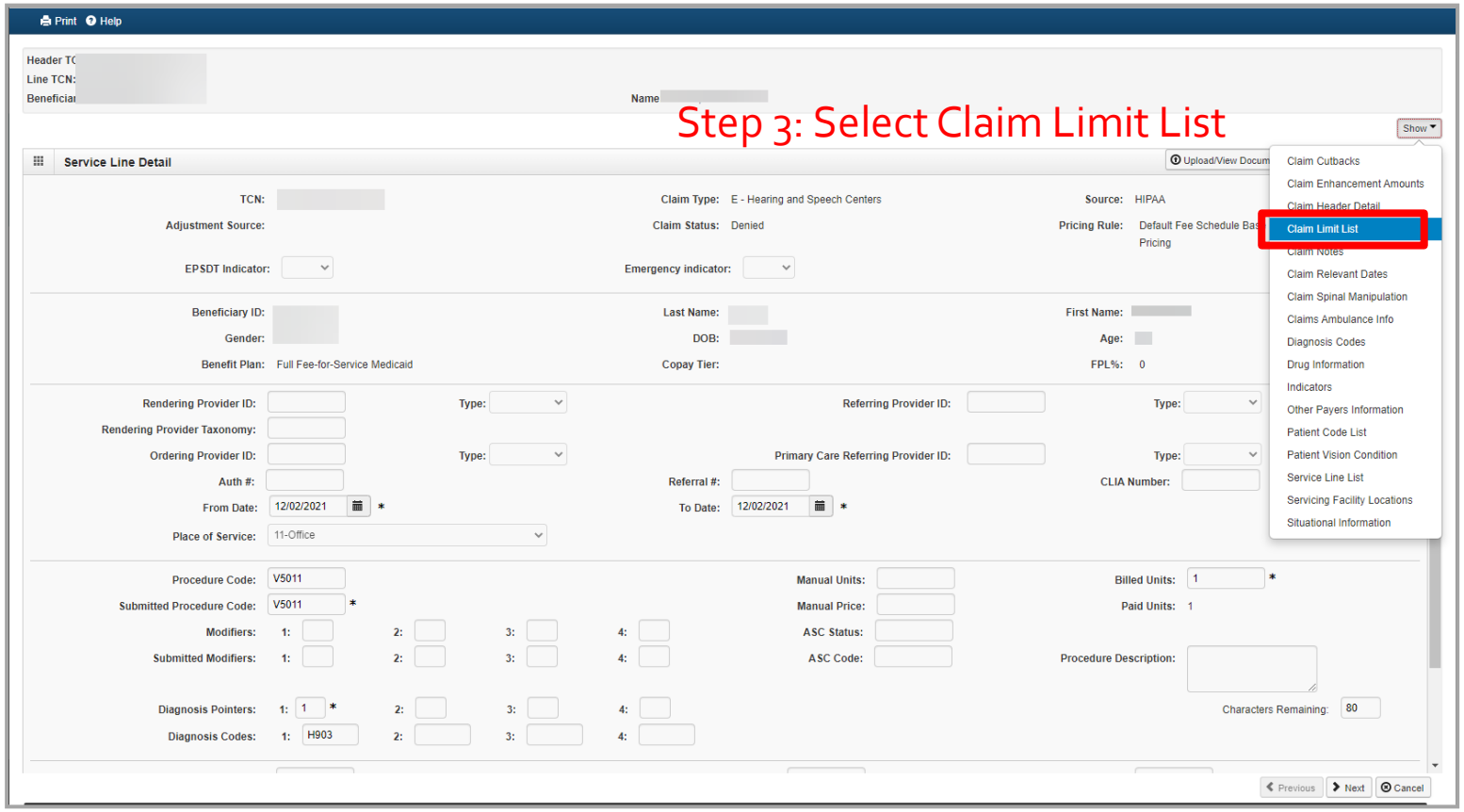
Claim Limit List

- Following the instructions from claim inquiry allows providers to easily assess claims in question.
- If there is suspicion that a claim was denied for limits exceeded or being a duplicate claim, it's helpful to follow the claim limit list instructions to determine.
- Step 1. Once a claim is selected by clicking on the TCN. Open the show dropdown from the header. Select Service Line List and the claim lines will display.
- Step 2. Select the claim line in question.



Claim Limit List

- Once the line TCN displays, click on the show dropdown. Select Claim Limit List to review other claims that it could be hitting up against.



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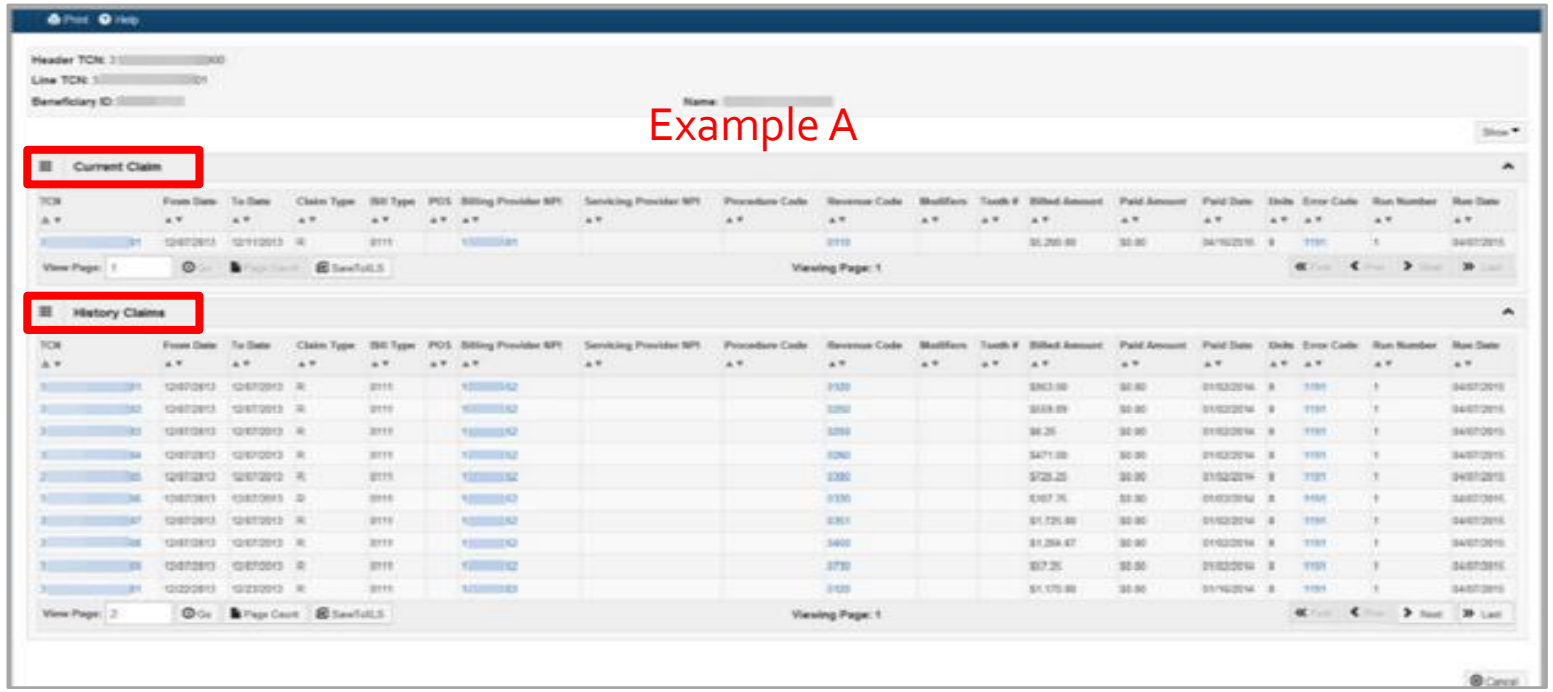
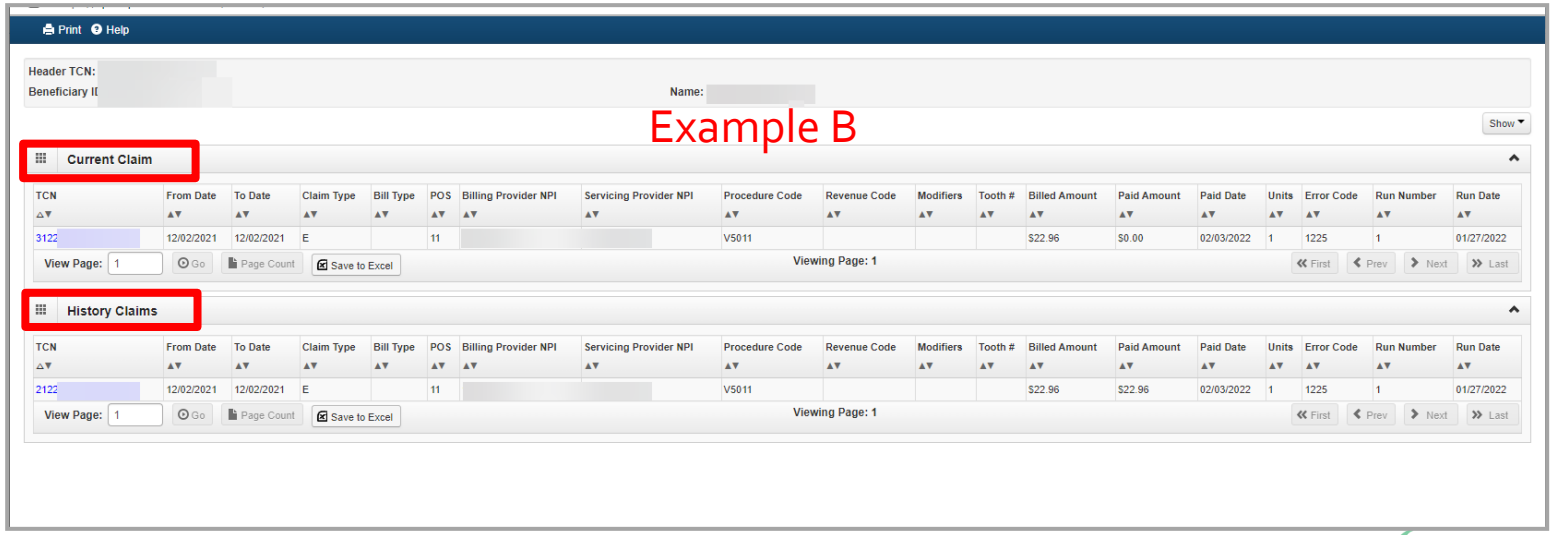
Claim Limit List

- After selecting the claim limit list function, the current TCN will display along with other historical claims that have been paid and the claim is hitting up against meaning it is a duplicate claim or units have already been billed meaning the current claim has exceeded the limit.
- Example A – denied for limit exceeded (CARC 119 / RARC N362)
- Example B – denied for duplicate (CARC 18 / RARC N532)





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Top Claim Denials

- Provider Support reviews claims data to help create resources for preventing future claim denials or adjusting paid claims within the timely filing guidelines.
- The next two slides go over top claim denials. Why the denial is happening and provides resources or instructions for preventing this on future claims.
- Claim Adjustment Reason and Remark Code Definitions: External Code Lists | X12

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CARC	RARC	Why is this denial happening?	Fixing the denial
96	N55	Billing NPI submitted on the claim is not associated to the submitter of the 837 file. Claims submitted by a Billing Agent is either not listed in the CHAMPS provider's enrollment file or the Billing Agent has been end-dated.	Ensure the billing agent is associated to the billing NPI. Billing agent under Step 8: Associate Billing Agent. • Associate a New Billing Agent & Authorize the 835/ERA • How to verify associated and authorized billing agents within a provider's CHAMPS enrollment information
B7	N570	Rendering NPI is not active on the claim date of service.	Verify the enrollment status, Provider Verification Tool. Have the Rendering or Referring provider update their enrollment information if needed, rebill claim.
208	N286	Referring NPI is not enrolled in CHAMPS.	
16	N286	Referring NPI not active.	
206	N286	Procedure code requires a referring or ordering NPI be reported on the claim.	Rebill with referring or ordering NPI if not on the claim. Verify the enrollment status if NPI is on the claim. Have the referring or ordering provider update their enrollment information if needed and rebill the claim.
183	N574	Provider specialty not allowed to be a Referring/Ordering/Attending NPI reported on the claim.	Verify that the rendering NPI is not also listed in the referring NPI field. The referring/ordering provider must be an individual provider (type 1 NPI). Referring providers must be one of the following practitioner types: Physician, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Dentist, Podiatrist, Optometrist, or Chiropractor (limited to spinal x-rays only). Refer to the MI Medicaid Provider Manual for additional details.
5	M77	The procedure code is inconsistent with the place of service.	Verify the place of service on the claim and check the Medicaid Code and Reference Tool to verify if there is a rate listed for the place of service billed (ex. Facility, Non-Facility).

CARC	RARC	Why is this denial happening?	Fixing the denial
96	N198	Rendering provider not associated with billing provider.	Review the individual rendering provider's enrollment information to make sure their NPI is associated to the billing (i.e., group) NPI in CHAMPS on the DOS. If the rendering provider is not associated to the group, the rendering provider will need to update their enrollment, Step 3: Associate Billing Provider.
185	N799	The rendering provider is not eligible to perform the service billed.	Review the rendering NPI on the claim to ensure it is the Type 1 Individual NPI and not the Type 2 Group NPI. Step 2: Determine CHAMPS Enrollment Type.
16	M77	Missing/incomplete/invalid/inappropriate place of service.	Verify the CPT code and the place of service on the claim. For example: INCAR-MA only covers inpatient hospital place of service, or a CPT code can only be done in an office setting.
22	N598	Beneficiary has other insurance so provider must bill other insurance first.	Verify primary coverage eligibility. Bill claim to the primary payer or rebill claim reporting primary payer information if they have already been billed.
24	N/A	Charges are covered under a capitation agreement/managed care plan.	Verify managed care plan eligibility instructions. Bill claim to the correct managed care plan.
18	N522	Exact duplicate of claim or service billed.	In CHAMPS claim inquire, go to service line, click on the Show Menu in the upper right corner, click on Claim Limit List. Instructions here.
119	N362	Benefit maximum for this time period or occurrence has been reached (Limit Exceeded).	
197	N/A	A Prior Authorization is required for the services performed.	Review the Medicaid Code & Rate Reference Tool for code requirements.
4	N657	Modifier required for service(s) performed.	

Public Health Emergency (PHE) (COVID-19) Resources

- PHE Ending
- Resources

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Public Health Emergency (PHE) Ending

- www.Michigan.gov/Coronavirus
- MDHHS Epidemic Orders
- MDHHS Medicaid Policies
- Federal Public Health Emergency Declarations

Policies labeled COVID-19 Response

- The Michigan Department of Health and Human Services (MDHHS) has issued many COVID-19 Response Medicaid Policy Bulletins and L-Letters which changed existing policy and processes under the guidance of the federal PHE. Many COVID-19 Response policy bulletins and L-Letters are intended to be time-limited, and MDHHS will notify providers of their termination.
- In preparation for the PHE ending, providers are asked to:
  - Review the Medicaid Policy Bulletins and L-Letters webpages to see which policies or L-letters may impact your provider type.
  - Verify beneficiary eligibility prior to services. Visit the Eligibility and Enrollment webpage for step-by-step instructions.
  - Help beneficiaries verify or update their contact information in MIBridges. Those who are unable to update their information in MIBridges can contact the Beneficiary Help Line at 1-800-642-3195 (TTY: 1-866-501-5656).

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Public Health Emergency (PHE) Ending Resources

Michigan will restart Medicaid eligibility renewals and certain waived policies that were in place during the pandemic when the federal PHE ends.

Learn more about the PHE ending and how you could be impacted by visiting www.michigan.gov/mdhhs/end-phe.

Additional Information:

- COVID-19 Response Database
- Telemedicine Database
- Stakeholder Toolkit

Contact us with questions or feedback:

- Policy questions email MSAPolicy@Michigan.gov
- Provider assistance email ProviderSupport@Michigan.gov or call 1-800-292-2550.

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Provider Resources

MDHHS website: www.michigan.gov/medicaidproviders

We continue to update our Provider Resources:

- CHAMPS Resources
- Listserv Instructions
- Provider Alerts
- Medicaid Provider Training Sessions

Provider Support:

ProviderSupport@Michigan.gov

1-800-292-2550

Thank you for participating in the Michigan Medicaid Program