

# 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

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# Policy Overview

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

# 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](#)

# 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](http://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
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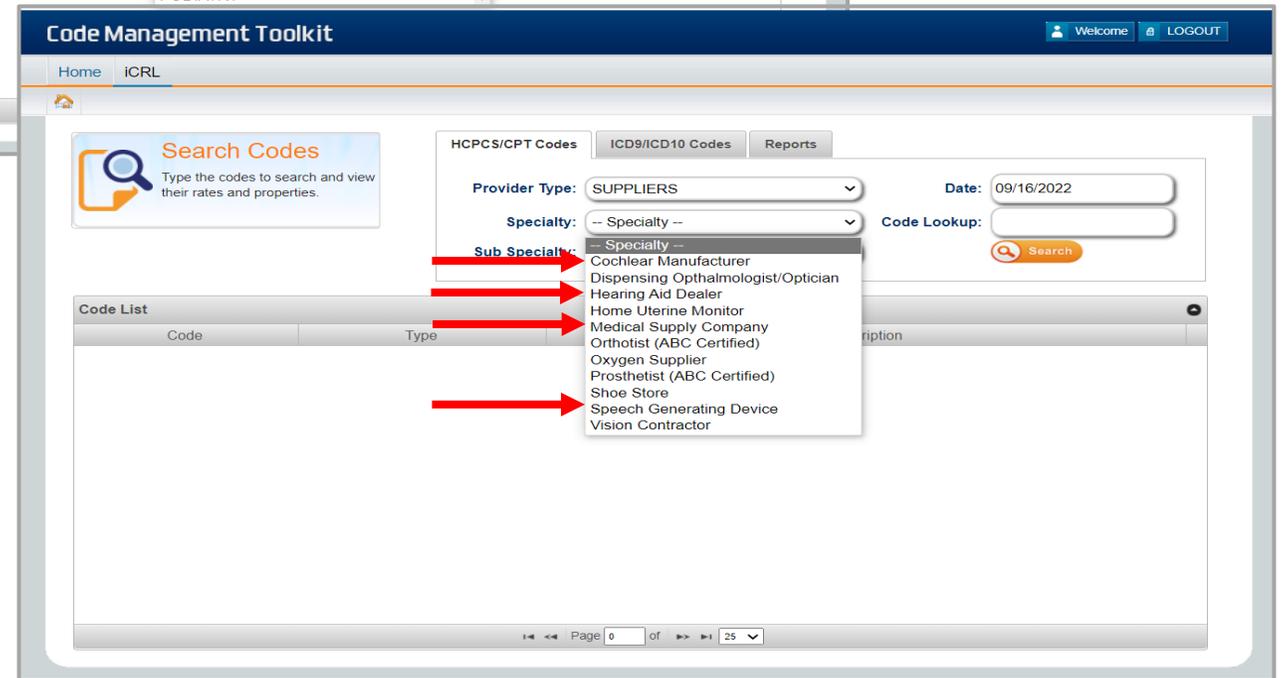
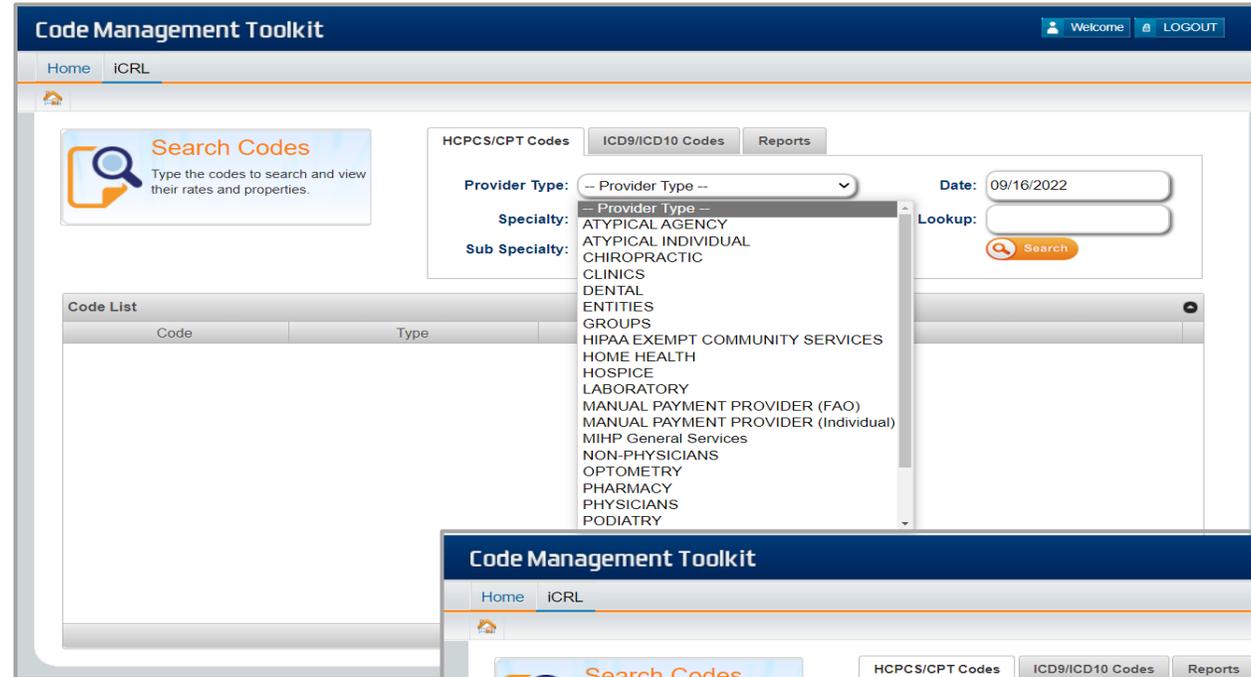
# Medicaid Code and Rate Reference Tool

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](#)

# 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.



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

**Code Management Toolkit** Home iCRL Welcome LOGOUT

Home iCRL

**Search Codes**  
Type the codes to search and view their rates and properties.

HCPSCS/CPT Codes ICD9/ICD10 Codes Reports

Provider Type: SUPPLIERS Date: 09/16/2022  
 Specialty: Hearing Aid Dealer Code Lookup: V5014  
 Sub Specialty: -- Sub Specialty -- Search

**Code List**

Code	Type	Description
<a href="#">V5014</a>	HCPSCS/CPT Codes	REPAIR/MODIFICATION OF A HEARING AID

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Home iCRL

**MDHHS Disclaimer:** The information on this page serves as a reference only. It does not guarantee that services are covered. Providers are instructed to refer to the Michigan Medicaid Provider Manual, MSA Bulletins and other relevant policy for specific coverage and reimbursement policies. This information can be found on the Medicaid Policy & Forms webpage. If there are discrepancies between the information on this page and the Provider Manual, such as rate or coverage determinations, they will be resolved in the favor of the Provider Manual language.

**Code Details**

**Code** : V5014 **Date Searched** : 09/16/2022  
**Category** : HCPSCS/CPT Codes **Date Printed** : 09/16/2022 13:54:26  
**Gender** : Both  
**Long Description** : REPAIR/MODIFICATION OF A HEARING AID

**Indicators**

Claim Type	Indicator Name	Indicator Value	Age Range	Exempt
	Medicaid Covered	Y-Yes		
	Modifier Required	RT-Right side		
	Modifier Required	LT-Left side		

**Age Ranges**

**CodeRates** **SpecialtyRates**

Claim Type	Modifier	Age Range	Place of Service	Rate Type	Rate
0-All				Rate	150.00

**Provider Type/Specialty/Subspecialty**

Provider Type	Specialty	Subspecialty
SUPPLIERS	Hearing Aid Dealer	No Subspecialty

**Associated Diagnosis**

**Limit Groups**

**NDC Details**  
No records to view

**Additional Code Detail**

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

# 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.

The screenshot displays the 'Service Lines' section of a software interface. At the top, there are input fields for 'Header TCN:' and 'Beneficiary ID', and a 'Name:' field. Below these is a 'Show' dropdown. The main area is a table with columns: TCN, Revenue Code, Procedure Code, Modifiers, Dental Attribute, From Date, To Date, Units, Submitted Charges, Approved Amount, and Claim Status. The table contains four rows of data. The 'Modifiers' column for the second row is highlighted with a red box, and the 'Procedure Code' for that row is also highlighted with a red box. The 'Claim Status' for all rows is 'Denied'. At the bottom of the table, there are controls for 'View Page: 1', 'Page Count', 'Save to Excel', and 'Viewing Page: 1'.

TCN	Revenue Code	Procedure Code	Modifiers	Dental Attribute	From Date	To Date	Units	Submitted Charges	Approved Amount	Claim Status
1		V5011			12/02/2021	12/02/2021	1	\$22.96	\$0.00	Denied
2		V5014			12/02/2021	12/02/2021	1	\$150.00	\$0.00	Denied
3		V5266			12/02/2021	12/02/2021	72	\$40.32	\$0.00	Denied
4		V5267			12/02/2021	12/02/2021	1	\$36.80	\$0.00	Denied

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

# 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](#)

# 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."

The screenshot shows the CHAMPS Provider Verification Details screen for an active provider. The interface includes a top navigation bar with 'My Inbox', 'Provider', 'Claims', 'Member', and 'PA' menus. A user profile bar shows the last login as '04 DEC, 2019 08:21 AM'. The breadcrumb trail is 'Provider Portal > Provider Verification'. The main content area is titled 'Provider Verification Details' and contains the following information:

NPI/Provider ID:	[Redacted]	Provider Name:	[Redacted]
Business Status:	Active	Primary Specialty:	Orthopedic Surgery
Current Business Elig. Date Range:	01/01/1972-03/01/2024	Specialty:	

Red arrows point to the 'Business Status: Active' and 'Current Business Elig. Date Range: 01/01/1972-03/01/2024' fields. A note at the bottom states: 'Providers with an 'Active' business status are only active through the Current Eligibility Date Range.'

The screenshot shows the CHAMPS Provider Verification Details screen for an inactive provider. The interface is similar to the active provider screen, but the last login is '26 SEP, 2022 12:33 PM'. The breadcrumb trail is 'Provider Portal > Provider Verification'. The main content area is titled 'Provider Verification Details' and contains the following information:

NPI/Provider ID:	[Redacted]	Provider Name:	[Redacted]
Business Status:	In-Active/Closed	Primary Specialty:	
Current Business Elig. Date Range:	12/01/2008-12/31/2999	Specialty:	

Red arrows point to the 'Business Status: In-Active/Closed' and 'Current Business Elig. Date Range: 12/01/2008-12/31/2999' fields. A note at the bottom states: 'Providers with an 'Active' business status are only active through the Current Eligibility Date Range.'

# 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

# 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](#)

# Hearing Services and Devices

MDHHS > Doing Business with MDHHS > Health Care Providers > Providers > Billing 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 menu, please refer to the following 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 conditions
- 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](http://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](mailto: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 Binaural Hearing Aid	\$900.00	1 per 5 Years	Y	
V5130		In Ear Binaural Hearing Aid	\$900.00	1 per 5 Years	Y	
V5140		Behind Ear Binaural Hearing Aid	\$900.00	1 per 5 Years	Y	
V5160		Dispensing Fee Binaural	\$336.32	1 per 5 Years		
V5171	LT/RT	Hearing Aid Monaural Itc	See Contract	1 per 5 Years		
V5172	LT/RT	Hearing Aid Monaural Itc	\$900.00	1 per 5 Years	Y	
V5181	LT/RT	Hearing Aid Monaural Bte	See Contract	1 per 5 Years		
V5200		Disp Fee Contralateral Monaural	\$195.37	1 per 5 Years		
V5211		Hearing Aid Binaural Itc/Itc	See Contract	1 per 5 Years		
V5212		Hearing Aid Binaural Itc/Itc	\$900.00	1 per 5 Years	Y	
V5213		Hearing Aid Binaural Itc/Bte	\$900.00	1 per 5 Years	Y	
V5214		Hearing Aid Binaural Itc/Itc	\$900.00	1 per 5 Years	Y	
V5215		Hearing Aid Binaural Itc/Itc	\$900.00	1 per 5 Years	Y	
V5221		Hearing Aid Binaural Itc/Bte	\$900.00	1 per 5 Years	Y	
V5221		Hearing Aid Binaural Bte/Bte	See Contract	1 per 5 Years		
V5240		Disp Fee Contralateral Binaural	\$336.32	1 per 5 Years		
V5241	LT/RT	Dispensing Fee, Monaural	\$195.37	1 per 5 Years		
V5242	LT/RT	Hearing Aid, Monaural, Cic	\$450.00	1 per 5 Years	Y	
V5243	LT/RT	Hearing Aid, Monaural, Itc	\$450.00	1 per 5 Years	Y	
V5244	LT/RT	Hearing Aid, Prog, Mon, Cic	\$450.00	1 per 5 Years	Y	
V5245	LT/RT	Hearing Aid, Prog, Mon, Itc	\$450.00	1 per 5 Years	Y	
V5246	LT/RT	Hearing Aid, Prog, Mon, Itc	\$450.00	1 per 5 Years	Y	
V5247	LT/RT	Hearing Aid, Prog, Mon, Bte	\$450.00	1 per 5 Years	Y	
V5248		Hearing Aid, Binaural, Cic	\$900.00	1 per 5 Years	Y	
V5249		Hearing Aid, Binaural, Itc	\$900.00	1 per 5 Years	Y	
V5250		Hearing Aid, Prog, Bin, Cic	\$900.00	1 per 5 Years	Y	

# 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](#)

# 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.

The screenshot displays the CHAMPS Member portal interface. At the top, there are navigation tabs: My Inbox, Provider, Claims, Member, and PA. The Member tab is selected. Below the navigation, there is a user profile section with a dropdown menu. The dropdown menu is open, and the 'ELIGIBILITY INQUIRY' option is highlighted with a red rectangular box. Below the navigation, there is a 'Latest updates' section with a 'System Notification' that reads: 'Due to R10c-1.7.0.2 Release, the CHAMPS system will be down between 7:00 PM EST Friday, November 1st through 2:00 AM EST Saturday, November 2nd, 2019. This outage will affect the CHAMPS system access for all functionality.' To the right of the notification is a 'Calendar' widget showing the date 7 November 2019, Thursday, 07:24. Below the notification is a 'My Reminders' section with a filter dropdown, a search bar, and a table with columns: Alert Type, Alert Message, Alert Date, Due Date, and Read. The table currently displays 'No Records Found!'.

*This presentation, including the screen captures, are based on the CHAMPS Full Access Profile. Additional features and tabs will vary based on the profile selected.*

## 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/MedicaidProvider](http://www.Michigan.gov/MedicaidProvider)>>CHAMPS>>Eligibility and Enrollment (Member Tab)

The screenshot shows the CHAMPS Member Eligibility Inquiry form. The top navigation bar includes the CHAMPS logo and tabs for My Inbox, Provider, Claims, Member, and PA. The user is logged in as a provider, with a last login of 05 MAR, 2020 10:09 AM. The page title is "Provider Portal > Member Eligibility Inquiry".

Below the navigation bar, there are "Close" and "Submit" buttons. The main content area contains the following instructions and criteria sets:

TO SUBMIT AN ELIGIBILITY INQUIRY ON A SPECIFIC MEMBER, COMPLETE ONE OF THE FOLLOWING CRITERIA SETS AND CLICK 'SUBMIT':

- MEMBER ID/CLIENT IDENTIFICATION NUMBER(CIN)/CARD NUMBER/PENDING ELIGIBILITY RID OR
- LAST NAME, FIRST NAME AND DATE OF BIRTH OR
- LAST NAME, FIRST NAME AND SSN OR
- SSN AND DATE OF BIRTH
- ADDITIONAL SEARCH OPTIONS (Use if needed with one of the Search Options above to obtain a unique member match) :
  - GENDER
  - ZIP CODE
  - CASE NUMBER

The form itself is titled "MEMBER ELIGIBILITY INQUIRY" and contains the following fields:

- SEARCH MA PENDING ELIGIBILITY:
- SEARCH BY SERVICE TYPE(S):
- SERVICING PROVIDER NPI/PROVIDER ID:  \*
- FILTER BY:  --SELECT--
- LAST NAME:
- DATE OF BIRTH:
- Gender:  --SELECT--
- MICHILD Case Number:
- INQUIRY START DATE:  03/05/2020  \*
- SSN:
- FIRST NAME:
- Zip Code:
- MA Case Number:
- INQUIRY END DATE:  03/05/2020  \*

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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.

The screenshot shows the CHAMPS Member Eligibility Inquiry page. At the top, there are navigation tabs for My Inbox, Provider, Claims, Member, and PA. The page displays member information including Member ID, Name, and a warning: "Warning: THIS NPI IS NOT LISTED. SEE CSHCS GUIDELINES." Below this, there are various fields for inquiry details such as INQUIRY DATE RANGE, GENDER, DATE OF BIRTH, CASE NUMBER, CASE PHONE, CASE EMAIL, COUNTY OF RESIDENCE, MAGI CATEGORY, MA PROGRAM CODE, CITIZENSHIP, and REDETERMINATION DATE. On the right side, there are status indicators for COMMERCIAL / OTHER, CSHCS RESTRICTIONS, MHP PCP, BMP PROVIDER RESTRICTION, INDICATORS, WORKER LOAD NUMBER, MDHHS PHONE, MDHHS COUNTY, and UIC. At the bottom, there is a table titled "BENEFIT PLANS" with columns for Benefit Plan Id, PET, Benefit Plan Type, CHAMPS Provider Id, Service Type Details, Created Date, Transaction Date, Start Date, and End Date. The first row in the table is highlighted with a red box and shows "CSHCS" as the Benefit Plan Id and "FEE FOR SERVICE" as the Benefit Plan Type.

Benefit Plan Id	PET	Benefit Plan Type	CHAMPS Provider Id	Service Type Details	Created Date	Transaction Date	Start Date	End Date
CSHCS		FEE FOR SERVICE		<a href="#">Click To View Service Types</a>	12/09/2021	12/09/2021	06/26/2022	09/26/2022

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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).

# 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.

Member ID: [REDACTED] Name: [REDACTED]

Info : Fee for Service Dental Coverage (Note: Refer to Medicaid Provider Manual / MDHHS website for details on covered services including PA, copay and other requirements. Some services may not be covered if age 21 and older.)

INQUIRY DATE RANGE: [REDACTED] **COMMERCIAL / OTHER: Y**  
GENDER: [REDACTED] CSHCS RESTRICTIONS: N  
DATE OF BIRTH: [REDACTED] **MHP PCP: Y**  
CASE NUMBER: [REDACTED] BMP PROVIDER RESTRICTION: N  
CASE PHONE: [REDACTED] EXT: [REDACTED] **INDICATORS: Y**  
CASE EMAIL: [REDACTED] COST SHARE MET: N  
COUNTY OF RESIDENCE: [REDACTED] CAP AMOUNT REMAINING(\$): [REDACTED]  
MAGI CATEGORY: [REDACTED] WORKER LOAD NUMBER: [REDACTED]  
MA PROGRAM CODE: [REDACTED] MDHHS PHONE: [REDACTED]  
CITIZENSHIP: [REDACTED] MDHHS COUNTY: [REDACTED]  
REDETERMINATION DATE: [REDACTED] UIC: [REDACTED]

[Print Member Summary](#)  
[Non Covered Service Types](#)

### BENEFIT PLANS

Benefit Plan Id	PET	Benefit Plan Type	CHAMPS Provider Id	Service Type Details	Created Date	Transaction Date	Start Date	End Date
MME-MC	MHP-COMM	MANAGED CARE	3397152	<a href="#">Click To View Service Types</a>	02/08/2020	02/08/2020	09/19/2022	09/19/2022
BHMA-MHP		MANAGED CARE	2813564	<a href="#">Click To View Service Types</a>	02/08/2020	02/08/2020	09/19/2022	09/19/2022
MA		FEE FOR SERVICE		<a href="#">Click To View Service Types</a>	02/08/2020	02/08/2020	09/19/2022	09/19/2022

View Page: 1 | Go | Page Count | Save to Excel | Viewing Page: 1 | First | Prev | Next | Last

### PATIENT PAY

Services Applicable	Patient Pay Amount	PPA Start Date	PPA End Date
LTC/Inpatient	0	09/19/2022	09/19/2022

View Page: 1 | Go | Page Count | Save to Excel | Viewing Page: 1 | First | Prev | Next | Last

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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](#)

The screenshot shows the CHAMPS Provider Portal interface. The top navigation bar includes 'My Inbox', 'Provider', 'Claims', 'Member', and 'PA'. The breadcrumb trail is 'Provider Portal > Member Eligibility Inquiry > Member Benefit Level > TPL'. The page displays member information (Member ID, Name) and a search bar. The 'INSURANCE DETAILS' section is highlighted with a red box and contains the following table:

PAYER NAME	PAYER ID	COVERAGE TYPE	BIN	PCN	RX GROUP	GROUP NUMBER	POLICY NUMBER	POLICY HOLDER ID	DATE LAST UPDATED	BEGIN DATE	END DATE
MEDICARE-ENROLLED IN MEDICARE ADVANTAGE PLAN	55555555	CC							11/12/2019	01/01/2020	12/31/2999
MEDICARE-ENROLLED IN PART B	44444444	BB							07/27/2015	08/01/2012	12/31/2999
MEDICARE-ENROLLED IN PART A	33333333	AA							07/27/2015	08/01/2012	12/31/2999
MEDICARE-ENROLLED IN MEDICARE PART D	66666666	DD							11/12/2019	01/01/2020	12/31/2999
EXPRESS SCRIPTS	30592020	RX	003858	MD	PHMEDCR				09/18/2021	01/01/2020	12/31/2022

Below the table, there are controls for 'View Page: 1', 'Page Count', 'Save to Excel', and 'Viewing Page: 1'. Navigation buttons for 'First', 'Prev', 'Next', and 'Last' are also present.

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

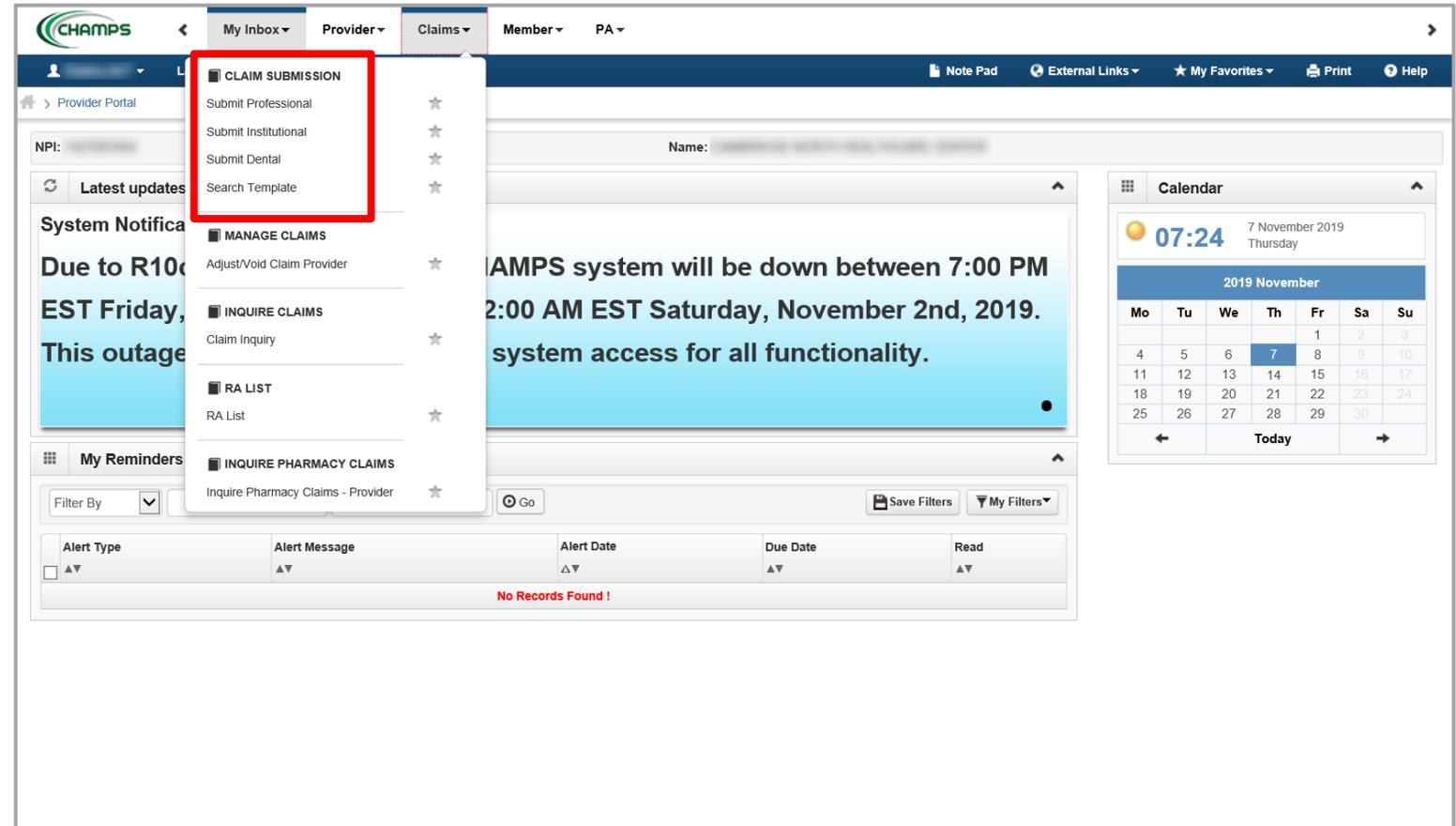
# Claim Submission

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](#)

# 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](#)



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

Professional Claim

Basic: Claims Info

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Address Line 1:  Address Line 2:

Address Line 3:  City/Town:

State/Province:  Country:

Is this Billing Location also the Service Facility Location?  Yes  No

Is the Billing Provider also the Rendering Provider?  Yes  No

RENDERING PROVIDER

Provider ID:  Type:  Taxonomy Code:

Is the Billing Provider also the Supervising Provider?  Yes  No

Is this service the result of a referral?  Yes  No

Is this service the result of a Primary Care Referral?  Yes  No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID:

Last Name:  First Name:  MI:  Suffix:

Date of Birth:  Gender:

Does the beneficiary have insurance other than Medicaid?  Yes  No

CLAIM INFORMATION

RELEVANT DATES

PRIOR AUTHORIZATION/REFERRAL CLAIM

Prior Authorization Number:  MDHS PA:  Yes  No Referral Number:

CLIA Number:

CLAIM NOTE

Is this claim related to Chiropractic Spinal Manipulation?  Yes  No

Is this a vision claim involving replacement lenses or frames?  Yes  No

Is this claim accident related?  Yes  No

Does this claim have backup documentation?  Yes  No

CLAIM DATA

Patient Account No:

Place of Service:

Diagnosis Code Category:

Diagnosis Code 1:  2:  3:  4:  Add another

AMBIANCE RELATED PROCEDURE

CONDITION INFORMATION

DELAY REASON

AMBULANCE INFORMATION

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date From:  Service Date To:

Place of Service:

Procedure Code:

Substituted Charges:

Units/Quantity:

EPSC/Family Planning:

EMG:

Modifiers: 1:  2:  3:  4:

Diagnosis Pointer: 1:  2:  3:  4:

Claim Note:

Characters Remaining: 80

Prior Authorization Number:  MDHS PA:  Yes  No Referral Number:  CLIA:

Rendering Provider ID (if different from header):  Type:  Taxonomy Code:

Ordering Provider ID:  Type:

Referring Provider ID (if different from header):  Type:

Primary Care Referring Provider ID (if different from header):  Type:

Is the Header Service Facility Location also the Service Line Facility Location?  Yes  No

National Drug Code:  Quantity:  Unit:  Quatifier:  Prescription/Line No:

Prescription Date:

AMBULANCE INFORMATION

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item information.

Click on Insurance info to enter each Line's insurance information.

Line No	Service Code	Proc. Code	Modifiers	Diagnosis Pointer	Submitted Charges	Hits	Prior Auth Number
From	To		1 2 3 4	1 2 3 4			

Institutional Claim

Basic: Claims Info

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID:  Type:  Taxonomy Code:

ATTENDING PROVIDER INFORMATION

Provider ID:  Type:  Taxonomy Code:

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID:

Last Name:  First Name:  MI:  Suffix:

Date of Birth:  Gender:

CLAIM INFORMATION

CLAIM DATA

Patient Control No:

Medical Record No:

Type of Bill:

Statement Dates: From:  To:

Admission Date/Time:

Admission Type:

Admission Source:

Discharge Hour:

Patient Status:

Principal Diagnosis Code:  PDA:

Diagnosis Code Category:

Auto Accident State/Province:

CONDITION INFORMATION

OCCURRENCE INFORMATION

OCCURRENCE SPAN INFORMATION

VALUE INFORMATION

DELAY REASON

OTHER INSURANCE INFORMATION

PRIOR AUTHORIZATION/REFERRAL NUMBER

Prior Authorization Number:  MDHS PA:  Yes  No PRO Number:

Referral Number:

DIAGNOSIS INFORMATION (Do not use decimals or spaces)

PROCEDURE INFORMATION

OPERATING PHYSICIAN INFORMATION

OTHER OPERATING PHYSICIAN INFORMATION

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN INFORMATION

CLAIM NOTE

Does this claim have backup documentation?  Yes  No

SERVICE LINE ITEM INFORMATION

SERVICE LINE ITEMS

Revenue Code:

HCPCS Code:

Service Date:

Modifiers: 1:  2:  3:  4:

HCPCS Description:

Characters Remaining: 80

Last Date of Service:

Service Units:

Total Line Charges:

Non-covered Line Charges:

Operating Physician ID (if different from header):  Type:

Other Operating Physician ID (if different from header):  Type:

Rendering Physician ID (if different from header):  Type:

Referring Physician ID (if different from header):  Type:

National Drug Code:  Quantity:  Unit:  Quatifier:  Prescription/Line No:

AMBULANCE INFORMATION

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item information.

Click on Insurance info to enter each Line's insurance information.

Line No	Revenue Code	HCPCS Code	Modifiers	Diagnosis Pointer	Units	Charges	Non-covered Charges
1	2	3	4	1	2	3	4

## 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 - **Ear Molds** should not be billed on the same date of service as the dispensing fee. 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.

## 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](#)

Print Help

### Submitted Professional Claim Details

TCN: [redacted] 000

Billing Provider ID: [redacted]

Billing Provider Name: [redacted]

Beneficiary ID: [redacted]

Beneficiary Name: [redacted]

Date of Service: 05/01/2022

Total Claim Charge: \$72.00

Total Number of Lines: 2

Upload Documents Print Close

# 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](#)

# 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](#)

The screenshot displays the CHAMPS Provider Portal interface. The top navigation bar includes 'My Inbox', 'Provider', 'Claims', 'Member', and 'PA'. A dropdown menu is open under 'Claims', showing options: 'CLAIM SUBMISSION' (with sub-items: Submit Professional, Submit Institutional, Submit Dental, Search Template), 'MANAGE CLAIMS' (with sub-item: Adjust/Void Claim Provider), 'INQUIRE CLAIMS' (with sub-item: Claim Inquiry, highlighted with a red box), 'RA LIST' (with sub-item: RA List), and 'INQUIRE PHARMACY CLAIMS' (with sub-item: Inquire Pharmacy Claims - Provider). The main content area features a system notification: 'CHAMPS system will be down between 7:00 PM 11/2/2019 and 12:00 AM EST Saturday, November 2nd, 2019. system access for all functionality.' To the right is a calendar for November 2019, showing the current date as Thursday, November 7, 2019, at 07:24. Below the notification is a 'My Reminders' section with a table header: 'Alert Type', 'Alert Message', 'Alert Date', 'Due Date', and 'Read'. The table currently displays 'No Records Found!'.

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

# Claim Inquiry

- Professional Claim Inquiry – [Video](#)
- Institutional Claim Inquiry - [Video](#)

CHAMPS My Inbox Provider Claims Member PA

Last Login: 20 SEP, 2022 09:26 AM

Provider Portal > Submit Professional Claim > Inquire Claims

**Inquire Claims**

From/To Dates: 01/01/2022 - 06/01/2022 And Reason Code: % And Remark Code: %

Filter By: And Filter By: With Status: In Claim: All Go Save Filters My Filters

TCN	From Date	To Date	Submitted Charges	Claim Status	Approved Amount	Pay Cycle Date	Reason Code	Remark Code
000	05/01/2022	05/01/2022	\$72.00	Denied	\$0.00		183	N574

View Page: 1 Page Count Save to Excel Viewing Page: 1

CHAMPS My Inbox Provider Claims Member PA

Last Login: 27 SEP, 2022 07:09 AM

Provider Portal > Inquire Claims

**Inquire Claims**

From/To Dates: 10/07/2021 - 10/07/2021 And Beneficiary ID: And Reason Code: % And Remark Code: %

Filter By: And Filter By: With Status: In Claim: All Go Save Filters My Filters

TCN	From Date	To Date	Submitted Charges	Claim Status	Approved Amount	Pay Cycle Date	Reason Code	Remark Code
000	10/07/2021	10/07/2021	\$22.96	Paid	\$22.96	03/16/2022	140, 16	MA114, MA27
000	10/07/2021	10/07/2021	\$22.96	Denied	\$0.00	02/16/2022	140, 16, 183, 96	MA114, MA27, N55, N574, N799

View Page: 1 Page Count Save to Excel Viewing Page: 1

# 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](#)

# 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.

Header TCN: [Redacted] Beneficiary ID: [Redacted] Name: [Redacted]

**Header Details**

TCN: [Redacted] Claim Type: E - Hearing and Speech Centers Source: HIPAA  
 Original TCN: [Redacted] Adjustment Source: [Redacted] Claim Status: Denied  
 No Of Lines: 4 Medicare: N Commercial: N  
 Related Cause: NO

Beneficiary ID: [Redacted] \* Last Name: [Redacted] First Name: JEANETTE  
 Gender: [Redacted] \* DOB: [Redacted] \* Age: 55  
 Patient Account Number: [Redacted] Place of Service: 11-Office  
 Admit Date: [Redacted]

Billing Provider ID: [Redacted] \* Type: NPI \* Pay To Provider ID: [Redacted] Type: NPI  
 Billing Provider Taxonomy: [Redacted] Vendor ID: [Redacted]  
 Rendering Provider ID: [Redacted] \* Type: NPI Referring Provider ID: [Redacted] Type: NPI  
 Rendering Provider Taxonomy: [Redacted] Supervising Provider ID: [Redacted]  
 Supervising Provider ID: [Redacted] Type: [Redacted] Primary Care Referring Provider ID: [Redacted] Type: [Redacted]  
 Auth #: [Redacted] Referral #: [Redacted] CLIA Number: [Redacted]  
 Diagnosis Codes: 1: H903 \* 2: [Redacted] 3: [Redacted] 4: [Redacted] 5: [Redacted] 6: [Redacted] 7: [Redacted] 8: [Redacted] Diagnosis Code Category: ICD-10-CM \*

**Step 1: Select Service Line List**

Header TCN: [Redacted] Beneficiary ID: [Redacted] Name: [Redacted]

**Service Lines**

Filter By [Redacted] And Filter By [Redacted] Go Save Filters My Filters

TCN	Revenue Code	Procedure Code	Modifiers	Dental Attribute	From Date	To Date	Units	Submitted Charges	Approved Amount	Claim Status
1		V5011			12/02/2021	12/02/2021	1	\$22.96	\$0.00	Denied
2		V5014			12/02/2021	12/02/2021	1	\$150.00	\$0.00	Denied
3		V5266			12/02/2021	12/02/2021	72	\$40.32	\$0.00	Denied
4		V5267			12/02/2021	12/02/2021	1	\$36.80	\$0.00	Denied

View Page: 1 Page Count Save to Excel Viewing Page: 1 First Prev Next Last

**Step 2: Select the 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.

Print Help

Header TCN: [Redacted]  
Line TCN: [Redacted]  
Beneficiary Name: [Redacted]

**Step 3: Select Claim Limit List**

Service Line Detail

TCN: [Redacted] Claim Type: E - Hearing and Speech Centers Source: HIPAA  
Adjustment Source: [Redacted] Claim Status: Denied Pricing Rule: Default Fee Schedule Base Pricing  
EPSDT Indicator: [Redacted] Emergency indicator: [Redacted]

Beneficiary ID: [Redacted] Last Name: [Redacted] First Name: [Redacted]  
Gender: [Redacted] DOB: [Redacted] Age: [Redacted]  
Benefit Plan: Full Fee-for-Service Medicaid Copay Tier: [Redacted] FPL%: 0

Rendering Provider ID: [Redacted] Type: [Redacted] Referring Provider ID: [Redacted] Type: [Redacted]  
Rendering Provider Taxonomy: [Redacted]  
Ordering Provider ID: [Redacted] Type: [Redacted] Primary Care Referring Provider ID: [Redacted] Type: [Redacted]  
Auth #: [Redacted] Referral #: [Redacted] CLIA Number: [Redacted]  
From Date: 12/02/2021 \* To Date: 12/02/2021 \*

Place of Service: 11-Office

Procedure Code: V5011 Manual Units: [Redacted] Billed Units: 1 \*  
Submitted Procedure Code: V5011 \* Manual Price: [Redacted] Paid Units: 1  
Modifiers: 1: [Redacted] 2: [Redacted] 3: [Redacted] 4: [Redacted] ASC Status: [Redacted]  
Submitted Modifiers: 1: [Redacted] 2: [Redacted] 3: [Redacted] 4: [Redacted] ASC Code: [Redacted] Procedure Description: [Redacted]  
Diagnosis Pointers: 1: 1 \* 2: [Redacted] 3: [Redacted] 4: [Redacted] Characters Remaining: 80  
Diagnosis Codes: 1: H903 2: [Redacted] 3: [Redacted] 4: [Redacted]

Claim Cutbacks  
Claim Enhancement Amounts  
Claim Header Detail  
**Claim Limit List**  
Claim Notes  
Claim Relevant Dates  
Claim Spinal Manipulation  
Claims Ambulance Info  
Diagnosis Codes  
Drug Information  
Indicators  
Other Payers Information  
Patient Code List  
Patient Vision Condition  
Service Line List  
Servicing Facility Locations  
Situational Information

Previous Next Cancel

## 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)

**Example A**

Header TCN: [REDACTED]																		
Line TCN: [REDACTED]																		
Beneficiary ID: [REDACTED]																		
Name: [REDACTED]																		
<b>Current Claim</b>																		
TCN	From Date	To Date	Claim Type	Bill Type	POS	Billing Provider NPI	Servicing Provider NPI	Procedure Code	Revenue Code	Modifiers	Tooth #	Billed Amount	Paid Amount	Paid Date	Units	Error Code	Run Number	Run Date
[REDACTED]	12/07/2013	12/11/2013	R		0115	[REDACTED]	[REDACTED]		0110			\$1,200.00	\$0.00	04/10/2016	0	1191	1	04/07/2016
<b>History Claims</b>																		
TCN	From Date	To Date	Claim Type	Bill Type	POS	Billing Provider NPI	Servicing Provider NPI	Procedure Code	Revenue Code	Modifiers	Tooth #	Billed Amount	Paid Amount	Paid Date	Units	Error Code	Run Number	Run Date
[REDACTED]	12/07/2013	12/07/2013	R		0115	[REDACTED]	[REDACTED]		0100			\$83.00	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/07/2013	12/07/2013	R		0110	[REDACTED]	[REDACTED]		0200			\$108.00	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/07/2013	12/07/2013	R		0110	[REDACTED]	[REDACTED]		0200			\$0.25	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/07/2013	12/07/2013	R		0115	[REDACTED]	[REDACTED]		0200			\$471.00	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/07/2013	12/07/2013	R		0115	[REDACTED]	[REDACTED]		0200			\$720.25	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/07/2013	12/07/2013	R		0115	[REDACTED]	[REDACTED]		0100			\$167.76	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/07/2013	12/07/2013	R		0115	[REDACTED]	[REDACTED]		0101			\$1,720.00	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/07/2013	12/07/2013	R		0115	[REDACTED]	[REDACTED]		0400			\$1,204.47	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/07/2013	12/07/2013	R		0115	[REDACTED]	[REDACTED]		0700			\$07.25	\$0.00	01/02/2014	0	1191	1	04/07/2016
[REDACTED]	12/22/2013	12/23/2013	R		0115	[REDACTED]	[REDACTED]		0100			\$1,170.00	\$0.00	01/16/2014	0	1191	1	04/07/2016

**Example B**

Header TCN: [REDACTED]																		
Beneficiary ID: [REDACTED]																		
Name: [REDACTED]																		
<b>Current Claim</b>																		
TCN	From Date	To Date	Claim Type	Bill Type	POS	Billing Provider NPI	Servicing Provider NPI	Procedure Code	Revenue Code	Modifiers	Tooth #	Billed Amount	Paid Amount	Paid Date	Units	Error Code	Run Number	Run Date
3122	12/02/2021	12/02/2021	E		11	[REDACTED]	[REDACTED]	V5011				\$22.96	\$0.00	02/03/2022	1	1225	1	01/27/2022
<b>History Claims</b>																		
TCN	From Date	To Date	Claim Type	Bill Type	POS	Billing Provider NPI	Servicing Provider NPI	Procedure Code	Revenue Code	Modifiers	Tooth #	Billed Amount	Paid Amount	Paid Date	Units	Error Code	Run Number	Run Date
2122	12/02/2021	12/02/2021	E		11	[REDACTED]	[REDACTED]	V5011				\$22.96	\$22.96	02/03/2022	1	1225	1	01/27/2022

# 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](#)

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.	<p>Ensure the billing agent is associated to the billing NPI. Billing agent under Step 8: Associate Billing Agent.</p> <ul style="list-style-type: none"> <li>• <a href="#">Associate a New Billing Agent &amp; Authorize the 835/ERA</a></li> <li>• <a href="#">How to verify associated and authorized billing agents within a provider's CHAMPS enrollment information</a></li> </ul>
B7	N570	Rendering NPI is not active on the claim date of service.	<p>Verify the enrollment status, <a href="#">Provider Verification Tool</a>. Have the Rendering or Referring provider update their enrollment information if needed, rebill claim.</p>
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.	<p>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.</p>
183	N574	Provider specialty not allowed to be a Referring/Ordering/Attending NPI reported on the claim.	<p>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 <a href="#">MI Medicaid Provider Manual</a> for additional details.</p>
5	M77	The procedure code is inconsistent with the place of service.	<p>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).</p>

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, <a href="#">Step 3: Associate Billing Provider</a> .
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. <a href="#">Step 2: Determine CHAMPS Enrollment Type</a> .
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.	<a href="#">Verify primary coverage eligibility</a> . 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 <a href="#">eligibility instructions</a> . 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. <a href="#">Instructions here</a> .
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 <a href="#">Medicaid Code &amp; Rate Reference Tool</a> for code requirements.
4	N657	Modifier required for service(s) performed.	

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

- PHE Ending
- Resources

## Public Health Emergency (PHE) Ending

- [www.Michigan.gov/Coronavirus](http://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).

# 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](http://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](mailto:MSAPolicy@Michigan.gov)
- Provider assistance email [ProviderSupport@Michigan.gov](mailto:ProviderSupport@Michigan.gov) or call 1-800-292-2550.

# Provider Resources



**MDHHS**

website: [www.michigan.gov/medicaidproviders](http://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](mailto:ProviderSupport@Michigan.gov)

1-800-292-2550



Thank you for participating in the Michigan Medicaid Program