MDHHS

Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

Michigan Osteopathic Association Meeting 11/3/2017

Professional Provider Billing Tips & Policy Information

"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

Topics

- Timely Filing Limitation Billing Policy
- Exceptions to Timely Filing Limits
- Emergency Room Billing for Professional Charges
- Referring/Ordering Provider
- Provider Verification Tool
- Billing the Beneficiary
- Determining Eligibility
- Third Party Liability (TPL) Review
- Spend-down (Deductible) Patient's Responsibilities
- Verifying Monthly Spenddown Amount
- Document Management Portal (DMP)
- Reminders

Timely Filing Limitation Billing Policy

MSA 16-37

Timely Filing Limits Billing Policy

- Each claim received and acknowledged by the MDHHS CHAMPS claims processing system receives a unique identifier called a Transaction Control Number (TCN). The TCN is found on the Remittance Advice (RA) and in CHAMPS.
- The Composition of the TCN is designed to reflect the date the claim was received (plus other elements). Position 3-4 = last 2 digits of the service year. Position 5-7 = Julian date.
- Example: 31170301000222100 0 = January 30th 2017
  31163651000222100 0 = December 30th 2016 (Leap Year)

Timely Filing Limits Billing Policy (cont.)

- Per MSA 16-37: Effective January 1, 2017, claims must be received and acknowledged by MDHHS within 12 months from the date of service (DOS).
- For professional and dental invoices, this will be calculated using the service line level “From” DOS.
- Claims for dates of service prior to January 1, 2017, that have been kept appropriately active, must be submitted no later than December 31, 2017.

Timely Filing Limits Billing Policy (cont.)

- Claims exceeding the new timely filing limits (over 1 year from the DOS) will be denied unless the claim meets exception(s) criteria.
  - Note: Claim notes/remarks/comments explaining the request for the exception are required.
- Claims rejected for Timely Filing Billing Limitation will reflect the Claim Adjustment Reason Code 29.
- **If DOS is on or after January 1, 2017:**
  - Rebilling claim denials every 120 days will no longer be required as this policy eliminates “continuous active review”.

Timely Filing Limits Billing Policy (cont.)

- **For DOS prior to January 1, 2017:**
  - Policy in effect included “continuous active review” which was defined by: To meet timely filing criteria the claim must be received and acknowledged within 12 months from the DOS and additionally must be billed within 120 days from the date of the last rejection.
  - Documentation of prior activity is always the responsibility of the provider.
  - New policy states that any claim or claim adjustments must be submitted within 1 year from the DOS and must be kept active every 120 days and will need to be resolved prior to December 31, 2017.
  - If not resolved by December 31, 2017, the claim will be denied.

Timely Filing Limits Billing Policy (cont.)

- Voids:
  - Medicaid allows timely filing limits to be bypassed when returning an overpayment. Void logic bypasses timely filing editing.
- Claim adjustments billing for late or additional charges:
  - For services rendered on or after January 1, 2017, must be submitted within twelve calendar months from the DOS.
  - As a reminder all claim void or adjustments require notes/remarks/comments that clearly explain why the money is being returned.

Exceptions to Timely Filing Limits

Exceptions to Timely Filing Limits

- Per the Michigan Medicaid Provider Manual (MPM), *Chapter* General Information for Providers, *Section* 12.3 Billing Limitation, exceptions may be made in the following circumstances:
  - Departmental administrative error occurred that can be documented.
  - Medicaid beneficiary eligibility/authorization was established retroactively for more than 12 months after the DOS. MSA 1038
  - Judicial action/mandate.
  - Medicare and or other primary coverage processing was delayed.

Exceptions to Timely Filing Limits (cont.)

- Provider returning overpayment (via claim replacement or void).
- Primary insurance taking back payment after timely filing limitation has passed: Provider must submit a copy of insurance letter or EOB from primary insurance showing date money was taken back from paid claim. The claim must be submitted within 120 days of the primary insurance letter or remit date. (text added per bulletin MSA 16-37)

- NOTE: *Retroactive provider enrollment is not considered an exception to the billing limitation.*

Emergency Room Billing

For Professional Charges

Emergency Room Billing

- This serves as a reminder to all providers that bill for emergency room charges. Per Medicaid Policy Bulletin 04-03 and Section 1.2 of the Practitioner Chapter within the Medicaid Provider Manual, effective for dates of service on or after January 1, 2004, the two-tiered fee screen for emergency department (ED) attending physician services is based on whether the beneficiary is treated and released from the ED or treated and admitted to the hospital/transferred to another hospital.
- ***Treated and Released:***
- When billing for the attending ED physician E/M service, the modifier **UD** must be used with the appropriate E/M procedure code to designate that the beneficiary was released (discharged) from the ED. This modifier must be placed in the first modifier position on the claim line to ensure correct processing. The **UD** modifier indicates the physician billing for the ED E/M service was the attending ED physician and allows the appropriate fee screen to be used. E/M services provided by other physicians in the ED must not use the UD modifier. Services billed in addition to the E/M service by the attending ED physician must not use the UD modifier.

Emergency Room Billing (cont.)

- ***Treated and Admitted/Transferred:***
- When billing for the attending ED physician E/M service, the modifier **UA** must be used with the appropriate E/M procedure code to designate that the beneficiary was admitted to the hospital or transferred to another hospital from the ED. This modifier must be placed in the first modifier position on the claim line to ensure correct processing. The **UA** modifier indicates the physician billing for the ED E/M service was the attending ED physician and allows the appropriate fee screen to be used. E/M services provided by other physicians in the ED must not use the UA modifier. Services billed in addition to the E/M service by the attending ED physician must not use the UA modifier.

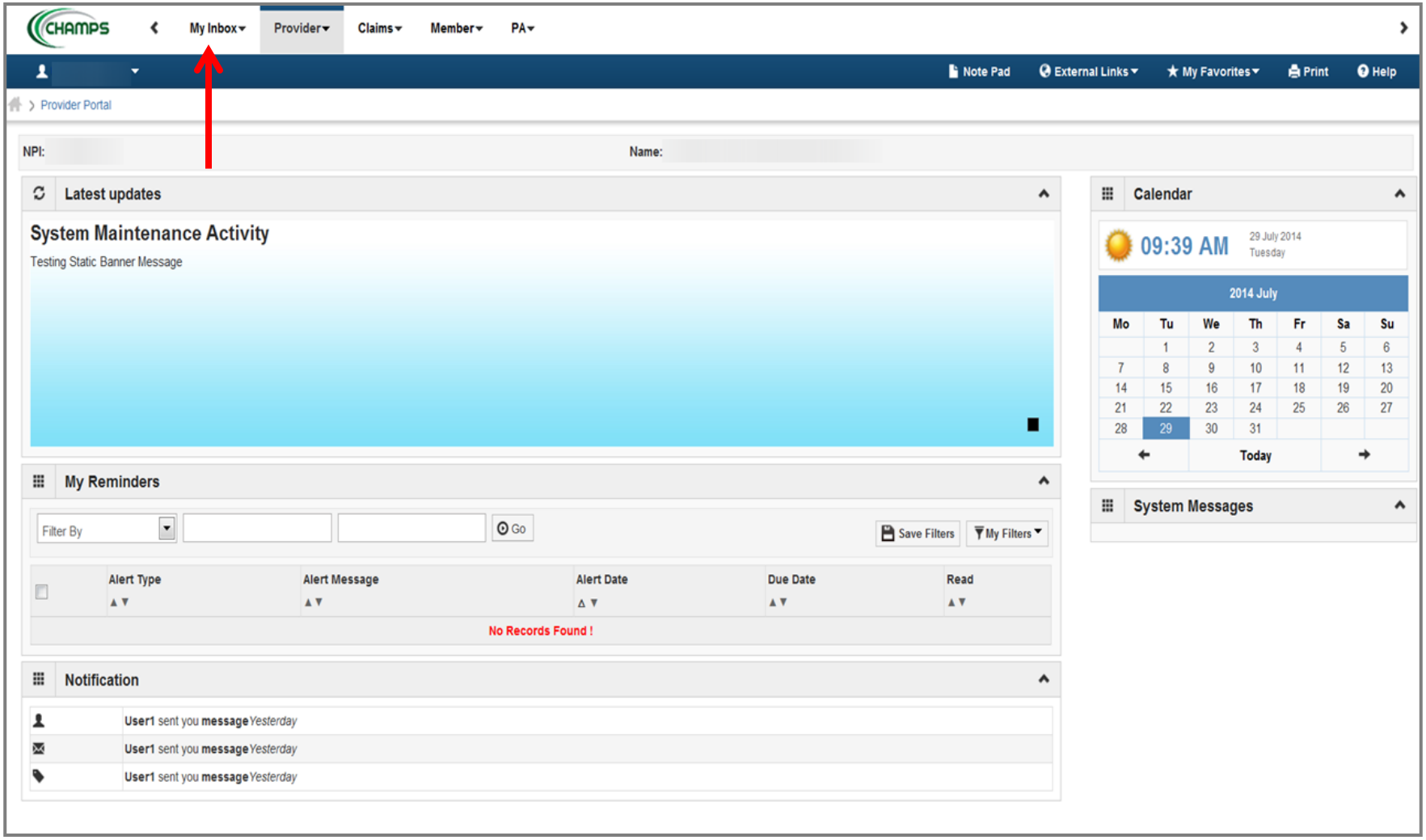
Referring/Ordering Provider

Referring/Ordering Provider

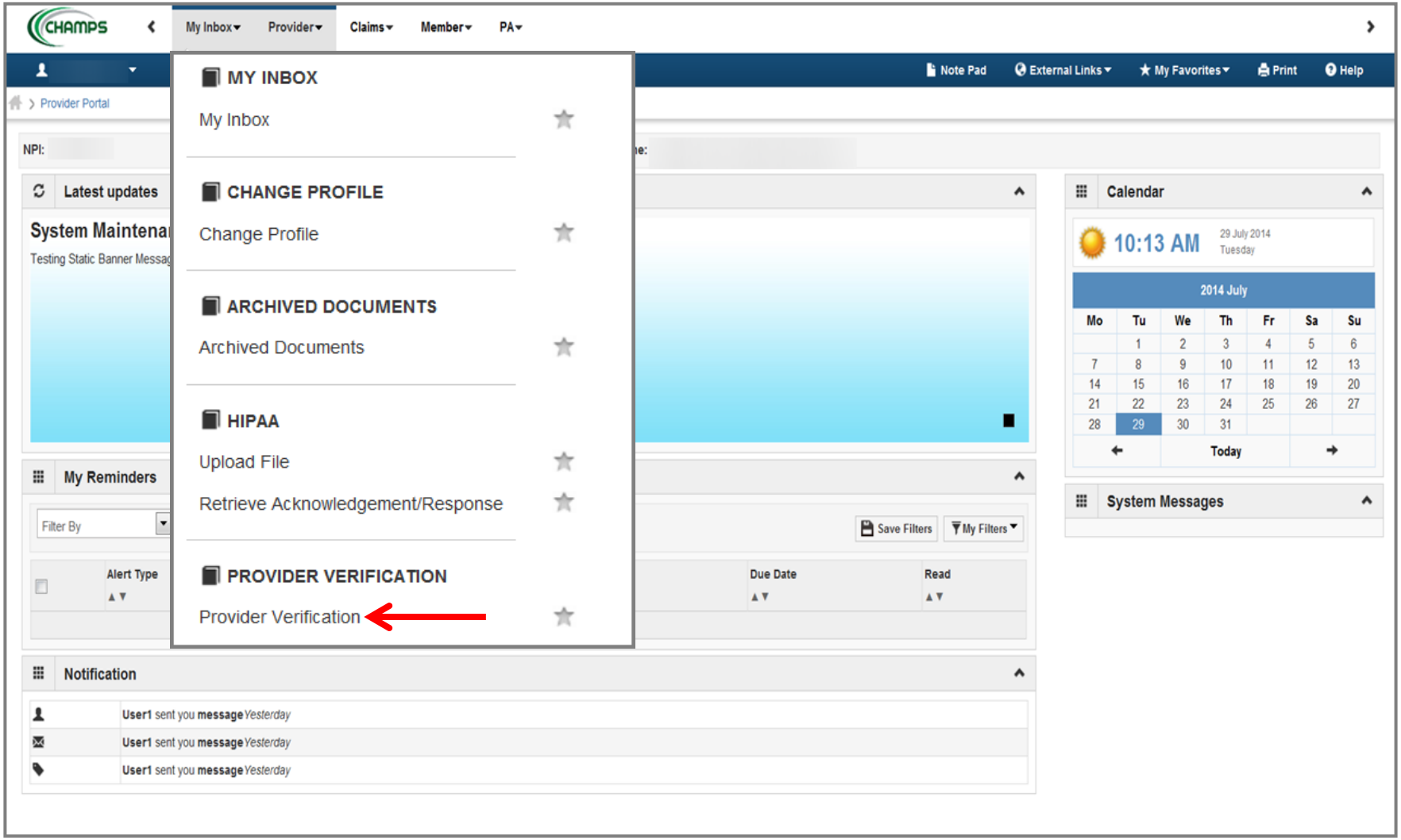
- MDHHS is continuing to see a high volume of claim denials where the referring/ordering provider is not enrolled in CHAMPS.
- Referring/ordering providers are encouraged to share their individual NPIs with rendering providers so they may submit the information required for payment of claims.
- A CHAMPS Provider Verification screen is available for providers to verify if an referring/ordering provider is enrolled/registered with Michigan Medicaid. Select the My Inbox tab within CHAMPS and choose the Provider Verification option in the drop-box menu. Enter the NPI of the referring/ordering provider and select Verify.
- Referring/ordering and attending providers must be enrolled and active in the Michigan Medicaid program on the date of service.
- Please refer to MSA 12-55 and MSA 13-17 for additional guidance.

Provider Verification Tool

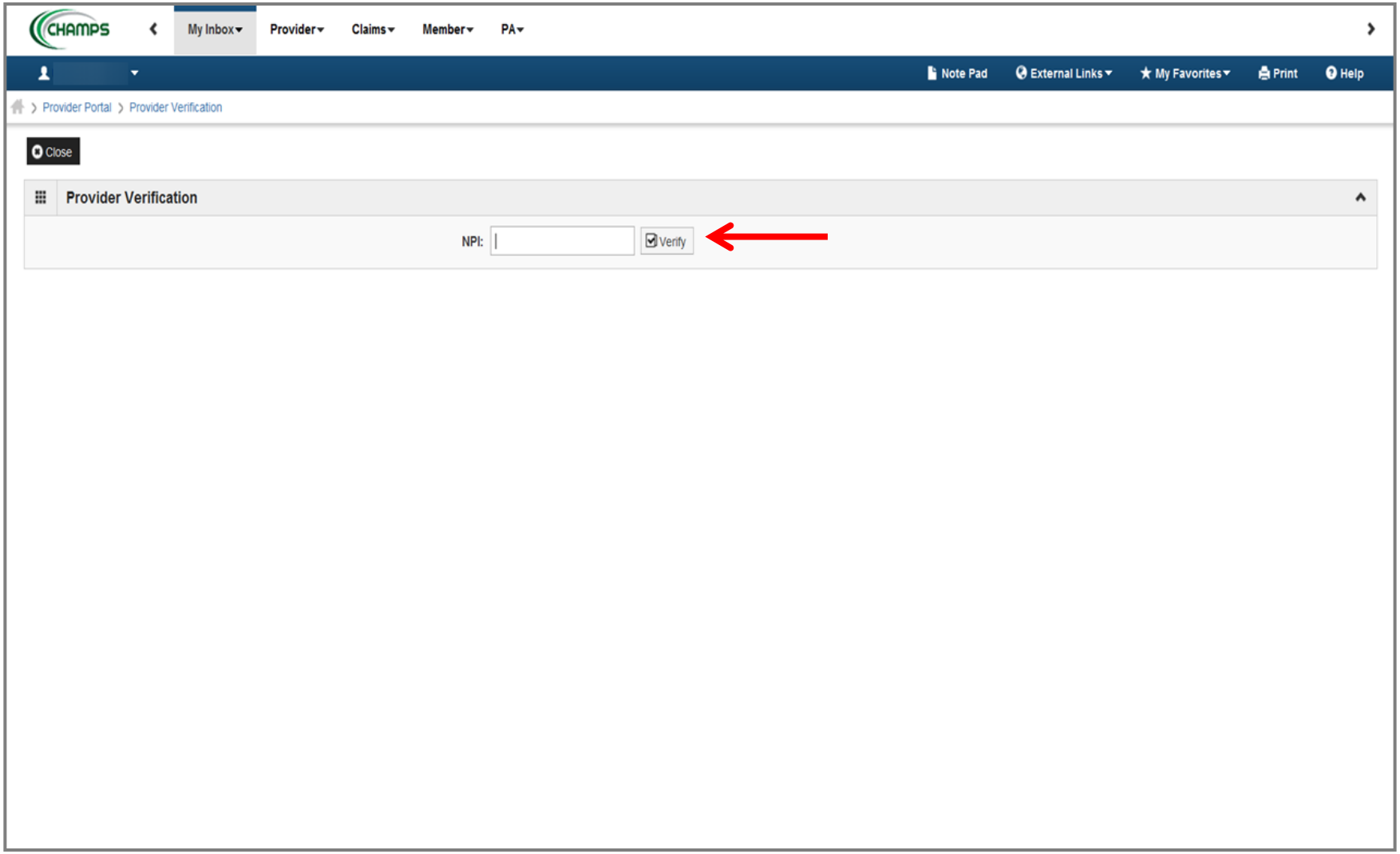
A tool used to verify if an attending/referring/ordering provider is enrolled with Michigan Medicaid



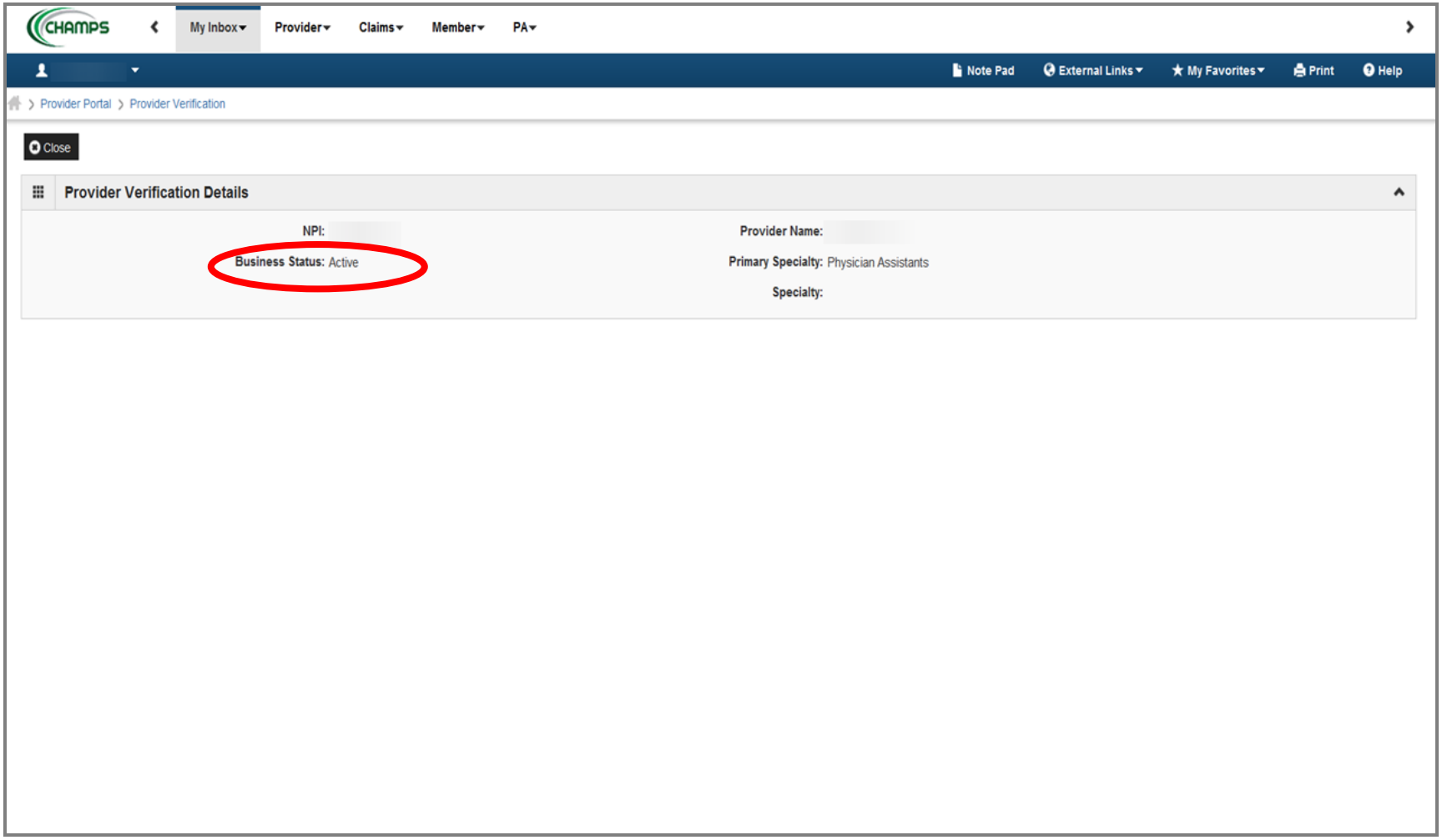
- Click the My Inbox tab



- Select Provider Verification



- Enter the Referring/Ordering NPI
- Click Verify



- If the provider is currently enrolled or was at one time enrolled the business status will show as active

Billing the Beneficiary

When Can the Beneficiary be Billed

Beneficiary Co-Payment Requirements

When the Beneficiary Cannot be Billed

When Can the Beneficiary be Billed?

- Chapter General Information For Providers in Section 11- Billing Beneficiaries
- Providers cannot bill beneficiaries for services except for the following situations:
  - A Medicaid copayment is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required copayment on the date of service.
  - A monthly patient-pay amount for inpatient hospital or nursing facility services. The local MDHHS caseworker determines the patient-pay amount. Non-covered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount.

When Can the Beneficiary be Billed (cont.)

- For nursing facility (NF), state-owned and-operated facilities or CMHSP-operated facilities there may be a determined financial liability or ability-to-pay amount separate from the MDHHS calculated patient-pay amount. This liability may be an individual, spouse, or parental responsibility. This responsibility is determined at initiation of services and is reviewed periodically.
- The provider has been notified by MDHHS that the beneficiary has an obligation to pay for part of, or all of, a service because services were applied to the beneficiary's Medicaid deductible amount

  (Commonly called Spend-down).

When Can the Beneficiary be Billed (cont.)

- If the beneficiary is enrolled in a Medicaid Health Plan (MHP) and the MHP did not authorize a service, and the beneficiary had prior knowledge that he was liable for the service. (It is the provider's responsibility to determine eligibility/enrollment status of each beneficiary at the time of treatment and to obtain the appropriate authorization for payment. Failure of the provider to obtain authorization does not create a payment liability for the beneficiary).
- Medicaid does not cover the service. If the beneficiary requests a service not covered by Medicaid, the provider may charge the beneficiary for the service if the beneficiary is told prior to rendering the service that it is not covered by Medicaid. If the beneficiary is not informed of Medicaid non-coverage until after the services have been rendered, the provider cannot bill the beneficiary.

When Can the Beneficiary be Billed (cont.)

- The beneficiary refuses Medicare Part A or B.
- Beneficiaries may be billed the amount other insurance paid to the policyholder if the beneficiary is the policyholder.
- The beneficiary is the policyholder of the other insurance and the beneficiary did not follow the rules of the other insurance (e.g., utilizing network providers/PA requirements/places of service).
- The provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

When Can the Beneficiary be Billed (cont.)

- It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any non-authorized or non-covered service the beneficiary elects to receive.

- Some services are rendered over a period of time (e.g., maternity care). Since Medicaid does not normally cover services when a beneficiary is not eligible for Medicaid, the provider is encouraged to advise the beneficiary prior to the onset of services that the beneficiary is responsible for any services rendered during any periods of ineligibility. Exceptions-some dental and DME supplies.

Beneficiary Co-Payment Requirements

- Beneficiary copayments may be required for the following Medicaid services:
  - Physician office visits (including those provided by podiatrists and nurse practitioners)
  - Chiropractic visits
  - Outpatient hospital clinic visits
  - Inpatient hospital stays
  - Non-emergency use of the emergency room
  - Dental services
  - Hearing aids
  - Pharmacy services
  - Vision services

When the Beneficiary Cannot be Billed

- When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for:
  - Medicaid-covered services. Providers must inform the beneficiary before the service is provided if Medicaid does not cover the service.
  - Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain PA, or the claim is over one year old and has never been billed to Medicaid, etc.
  - The difference between the provider's charge and the Medicaid payment for a service.
  - Missed appointments.
  - Copying of medical records for the purpose of supplying them to another health care provider.
- If a provider is not enrolled in Medicaid, they do not have to follow Medicaid guidelines about reimbursement, even if the beneficiary has Medicare as primary.

Determining Eligibility

Requirement for Verifying Beneficiary Eligibility

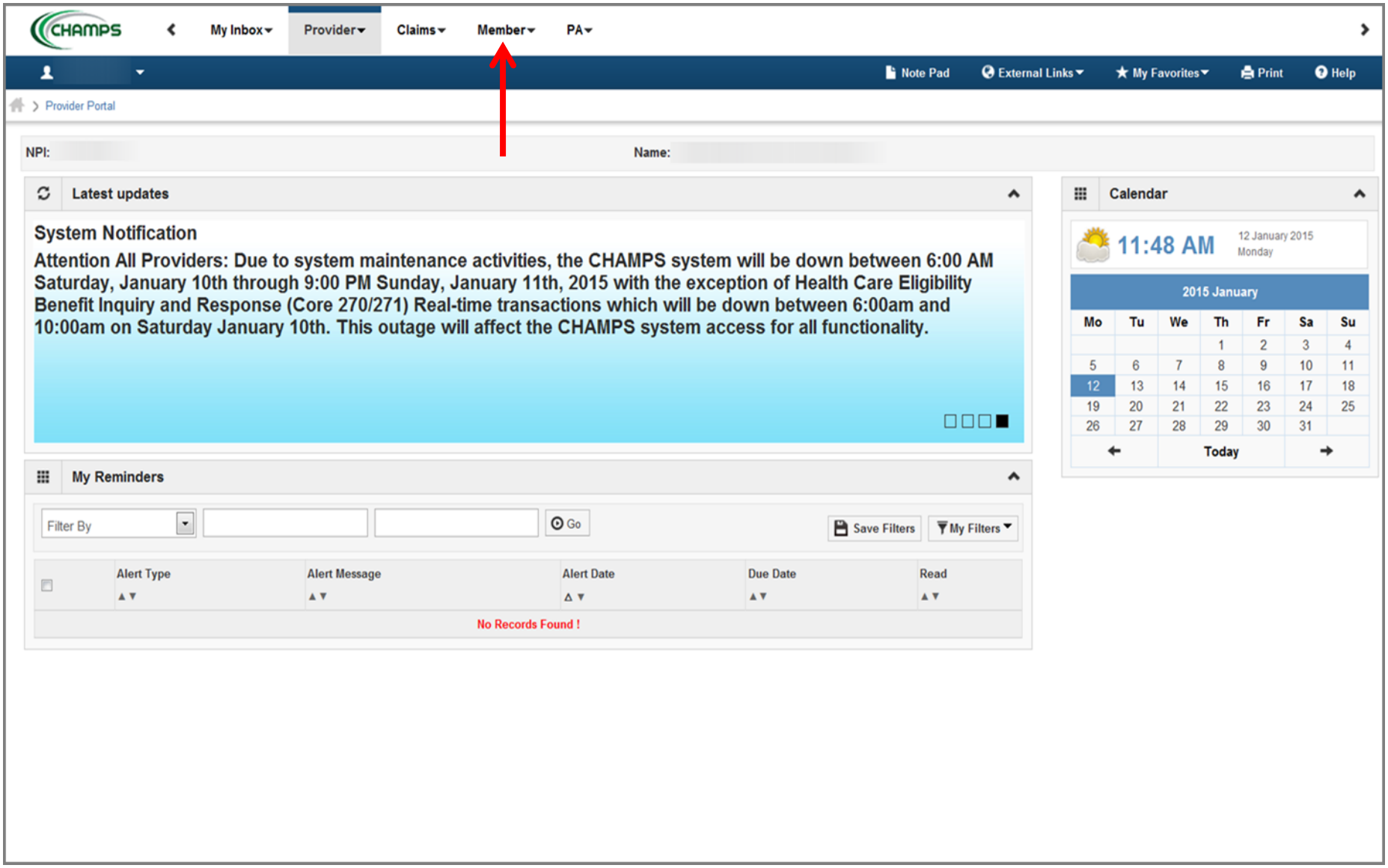
Requirement for Verifying Beneficiary Eligibility

- Per the Medicaid Provider Manual, Chapter Beneficiary Eligibility, coverage determination is the responsibility in most cases by the local county office of Michigan Department of Health and Human Services (MDHHS). Once eligibility is established CHAMPS will issue a mihealth card for new beneficiaries.
- Because of the nature of Medicaid eligibility, coverages/benefit plan assignments may change from month to month and it is necessary for providers to always verify coverage prior to rendering any services.

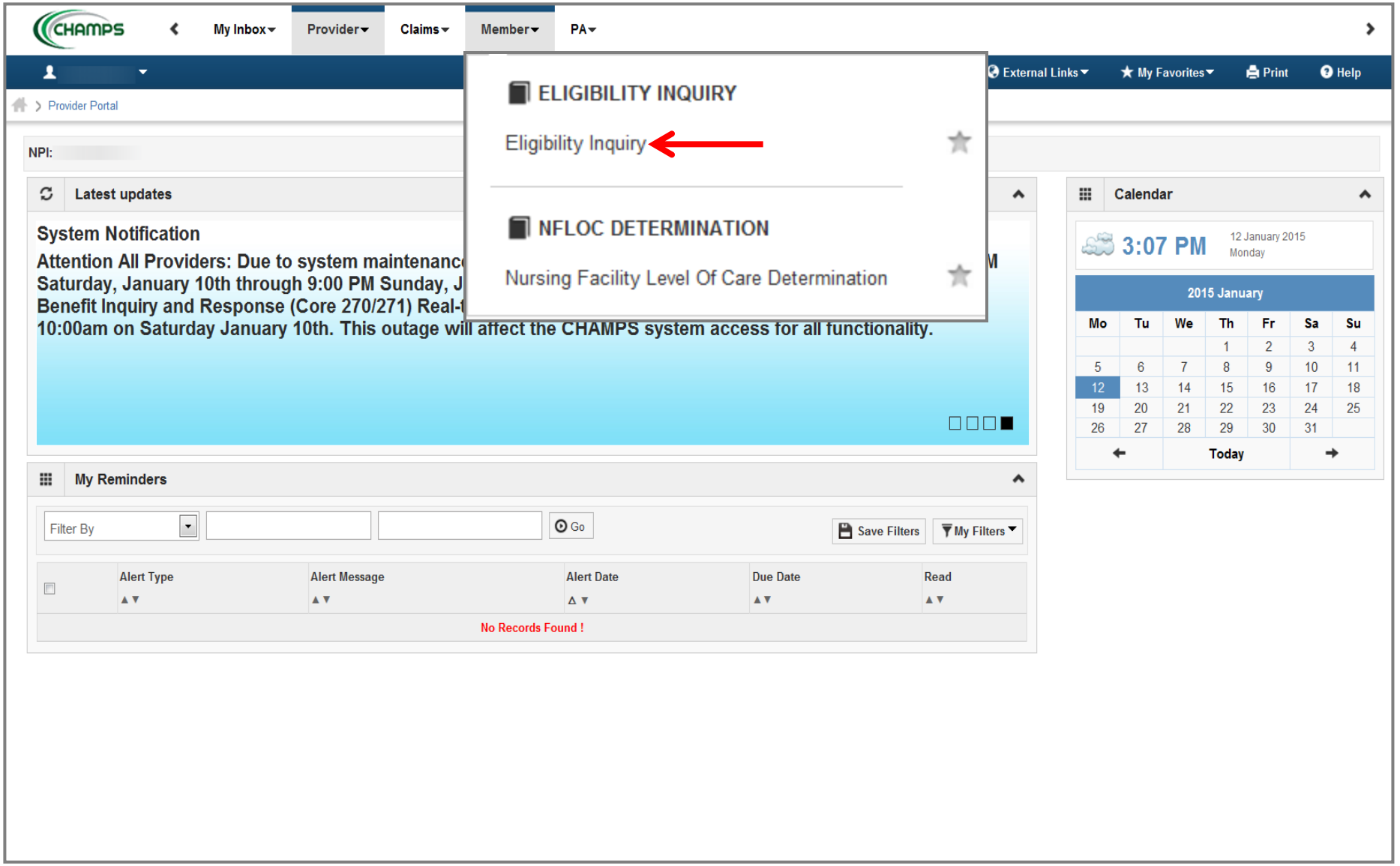
Requirement for Verifying Beneficiary Eligibility (cont.)

- Providers need to verify eligibility within CHAMPS, MPHI, or other vendor services prior to rendering services.
- It's the providers responsibility to grant access to their billing agent/companies in order to verify eligibility.
- To verify eligibility beyond a year: Please contact Provider Support.

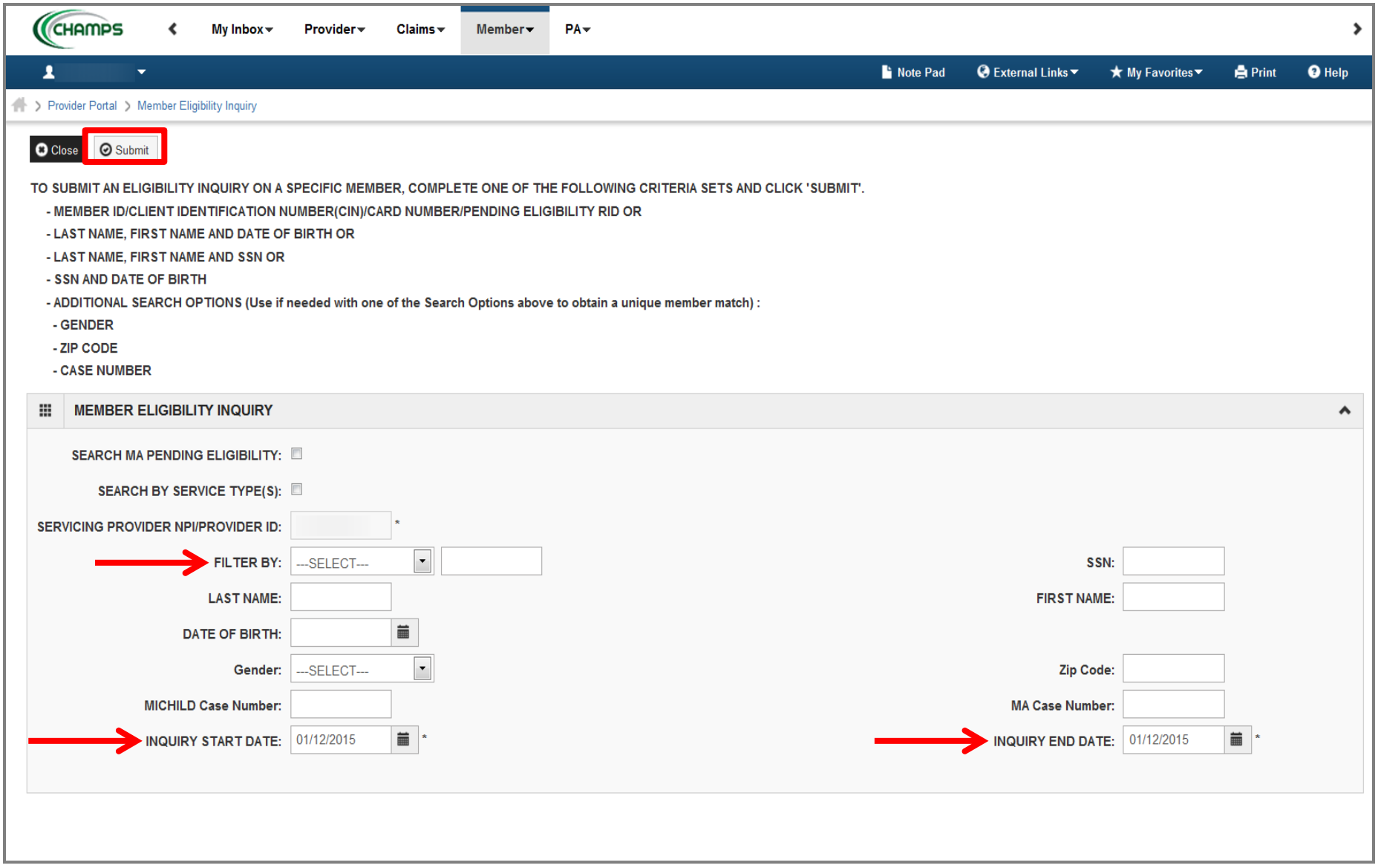
- CHAMPS profiles that can verify beneficiary eligibility:
  - CHAMPS Full Access
  - CHAMPS Limited Access
  - Eligibility Inquiry



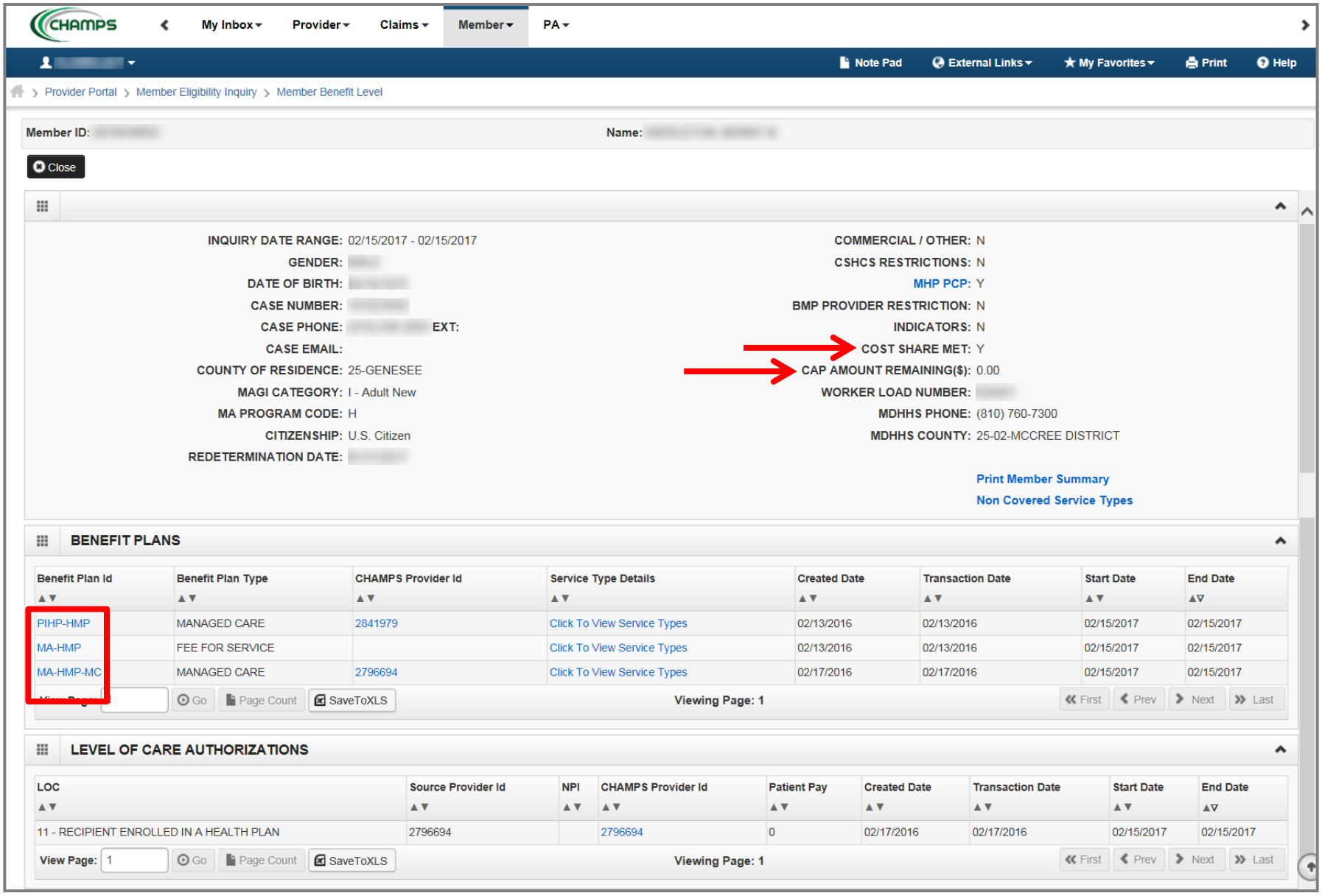
- Click the Member tab



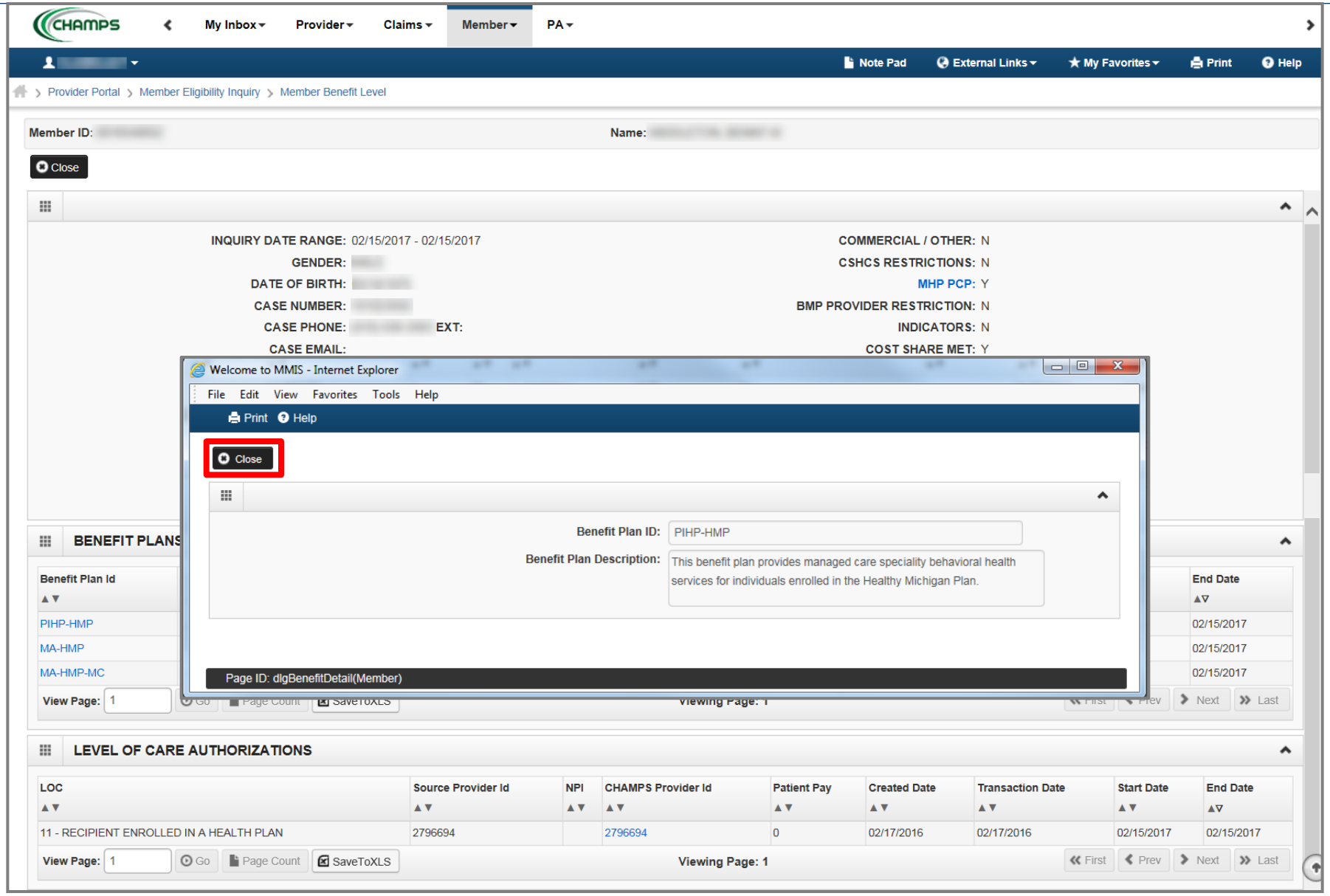
- Select the Eligibility Inquiry option



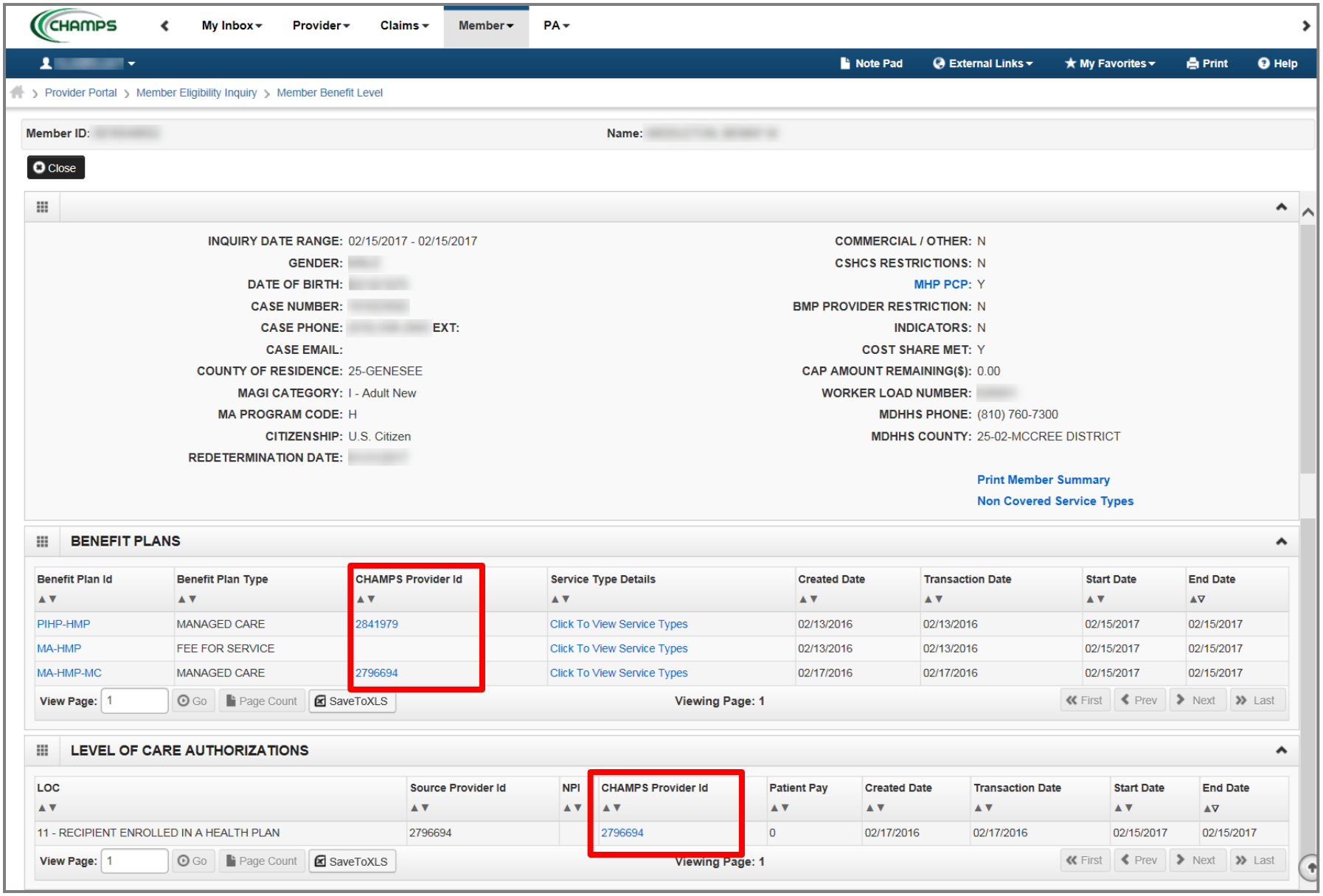
- Select the Filter By criteria from the drop-down selection
- Inquiry start date and end date default to the system date/current date. If you want another date click on the calendar option to change.
- Click Submit



- Click the hyperlink PHIP-HMP within the Benefit Plan ID



- Benefit Plan ID and Description are provided
- Click close to return back to the Benefit Plans List



- Click on the CHAMPS Provider ID hyperlink 2841979 to determine what managed care plan the beneficiary is enrolled in

Third Party Liability (TPL) Review

Third Party Liability (TPL) Review

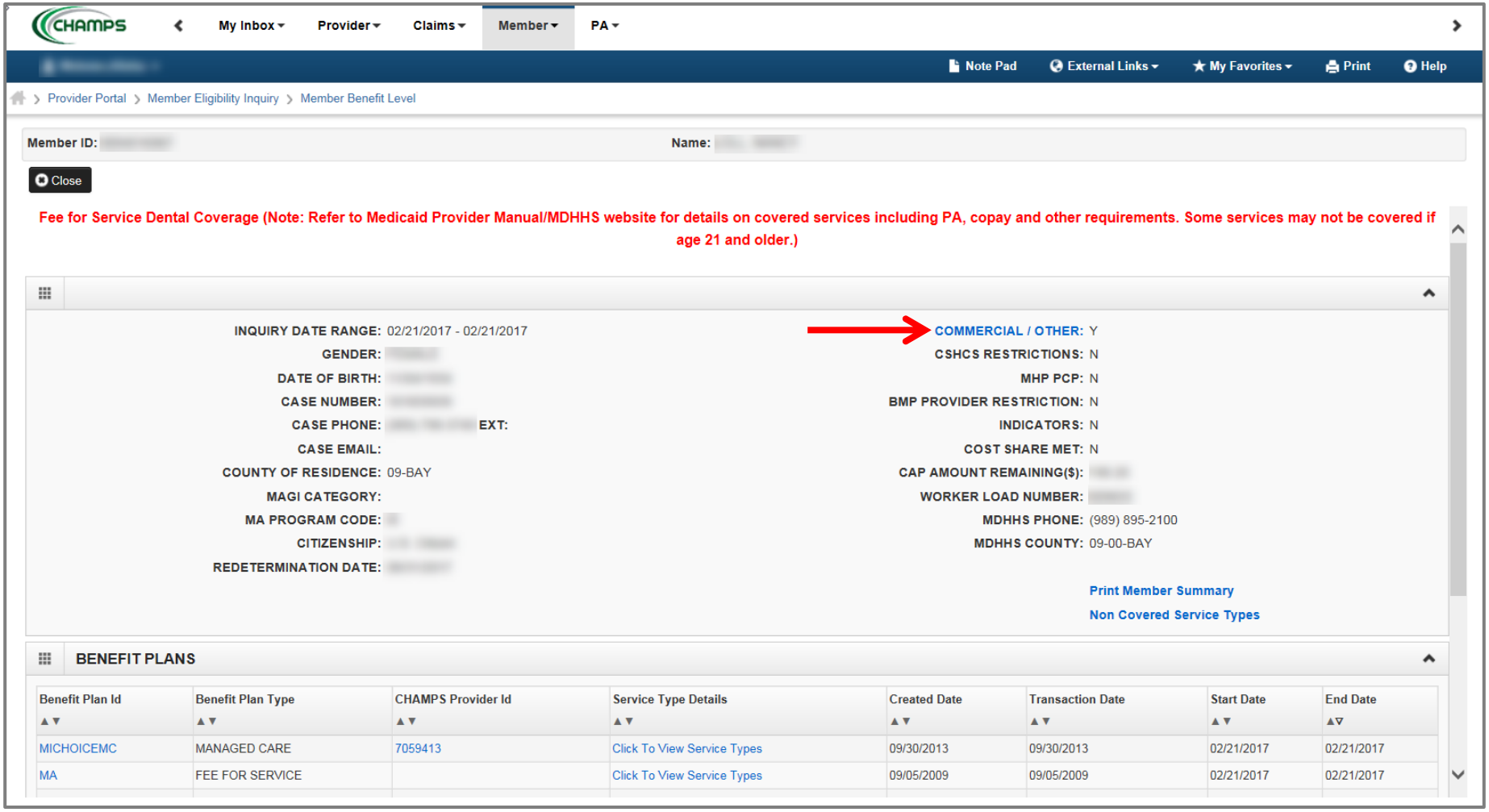
- Save this link to your favorites: www.michigan.gov/reporttpl
- MDHHS is receiving monthly files from BCBS and BCN.
  - Files loaded by the 15th of each month.
  - TPL is no longer making many changes to the TPL coverage file related to BCBS or BCN.
  - If a change, start date or termination date has happened within the last 30-60 days to BCBS or BCN coverage, MDHHS will receive the update in the next monthly file. There is no need to submit the Insurance Coverage Request Form (DCH-0078).

Third Party Liability (TPL) Review (cont.)

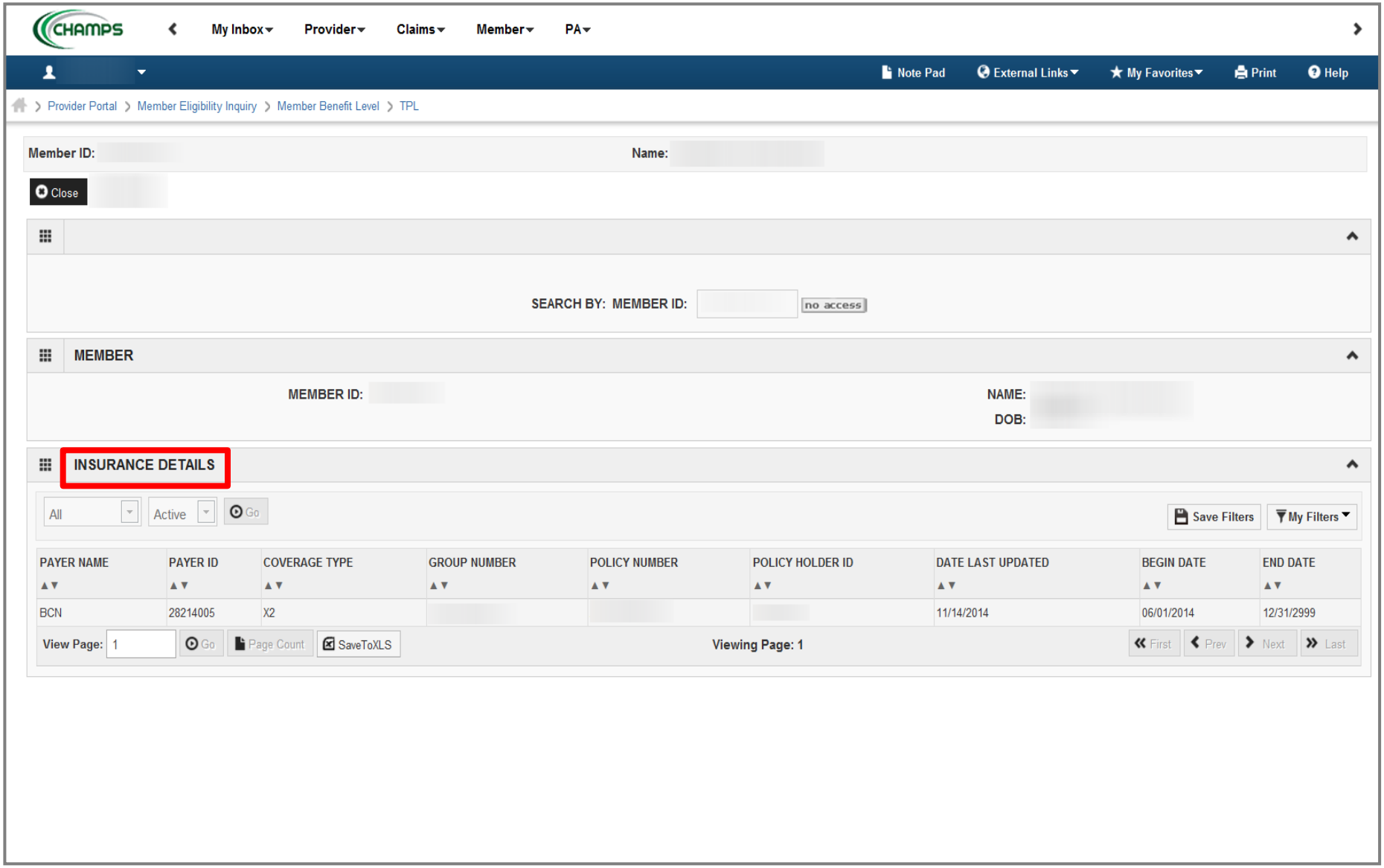
- **November 05, 2014: UPDATE:** In regards to the message posted on September 23, 2014 for ALL Providers: MDHHS Third Party Liability (TPL) will no longer add, update, or term records to match web-DENIS. Providers are asked to please contact Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN) for any questions related to loaded coverage. If CHAMPS and/or web-DENIS indicate active BCBSM or BCN coverage, please follow all Coordination of Benefits (COB) rules when submitting Medicaid claims.
- **September 23, 2014: Attention ALL Providers:** Effective September 21, 2014, coverage that is received from Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN) will be loaded directly into the CHAMPS TPL Coverage File. MDHHS Third Party Liability (TPL) will no longer update these records unless changes are available in web-DENIS after the last load date of eligibility from the National Roster File. Providers are asked to please contact BCBSM/BCN for any questions related to loaded coverage.

Third Party Liability (TPL) Review (cont.)

- TPL Billing Tips:
  - Please follow the primary insurance guidelines prior to submitting a claim to Medicaid.
  - Use the Claim Adjustment Reason Code (CARC) provided by the other insurance Explanation of Benefits (EOB), or use the closest match found using Washington Publishing Company.
  - In special or unique situations, adding comments to the claim may assist claims processing in reviewing the claim.



- If a beneficiary has a primary payer on file for the date of service being checked, the Commercial/Other will be Y
- Click the Commercial/Other Hyperlink to view the primary payer on file



- The primary payer information will display, including the coverage type, group number, policy number, date updated and begin and end dates

Spend-down (Deductible) Patient's Responsibilities

Spend-down also called Deductible
Medicaid Deductible Beneficiaries-Process
The Self-Pay Patient
Billing Instructions

Spend-down also called Deductible

- Provider Manual in the Chapter **Beneficiary Eligibility**
- **Section 4-Medicaid Deductible Beneficiaries** (Spenddown)
- Medicaid deductible means that the beneficiary must incur ***medical expenses*** each month equal to, or in excess of, an amount determined by the local MDHHS case worker to qualify for Medicaid.
- **Process:** Beneficiary presents proof of ANY medical expense incurred to the MDHHS worker. Items they can use e.g., care from hospitals, doctors, clinics, dentists, drugs, medical supplies and equipment, health insurance premiums, transportation to get medical care, personal assistance services, adult home help services, and other services from Community Mental Health.
- Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. Provider would not have to verify concrete amounts via EOB-this will expedite the process to get eligibility started for the beneficiary.
- **Beneficiary should be advised to contact their respective MDHHS local office caseworkers within 10 days of receipt of any charges they may use to satisfy their deductible.**

Medicaid Deductible Beneficiaries-Process (cont.)

- The MDHHS local county case worker will review documentation and determine beneficiary liability **and the first date of Medicaid eligibility.**
- **FIRST DATE of eligibility:** Once calculated, the caseworker sends letters to those providers whose service are entirely the beneficiary responsibility in whole or in part. The case worker also sends this documentation to the beneficiary.
- The local MDHHS case worker will update the system with applicable benefit plan=MA or MA-ESO.
- Once the deductible amount is incurred, eligibility is established through the end of the month. This process starts over again as eligibility is established on a month by month basis.
- Before a provider bills Medicaid, coverage must be verified. Providers may bill Medicaid for any covered services rendered during the period where eligibility has been loaded.

Medicaid Deductible Beneficiaries

- It is the provider's option to bill Medicaid if the beneficiary has paid the provider for services rendered. MDHHS encourages the provider to return the beneficiary's payment and bill Medicaid for the service. If the provider decides to bill Medicaid, all money the beneficiary paid over and above the amount identified as the beneficiary responsibility on the Medicaid deductible letter, must be returned.
- If the provider has decided to bill Medicaid, the beneficiary cannot be charged more than indicated on the letter from the local MDHHS office (plus co-payment).
- Are persons on Spend-down considered retroactive eligible? Yes, they actually have no coverage and/or guarantee of coverage.
- There is always a period of retroactive eligibility because bills have to be incurred before the deductible amount is met. Coverage may be applied retroactively up to a period of three months from the current month. In this situation, the local MDHHS office may apply these old bills to the past three months or may prospectively apply them to the next several months. Coverage dates may be affected even by the date the bill was presented to the MDHHS worker.

The Self-Pay Patient

- When providing services to a Spend-down patient, make sure this is handled as a cash patient; immediate payment is not required but payment arrangements should be made.
- Turn over the responsibility of follow up to the client or set up a Tickler File.
- Submit bills to the MDHHS directly to ensure eligibility gets calculated ASAP.

Billing Instructions

- Beneficiaries are responsible for payment of expenses that were incurred to meet the deductible amount. Payment for these services do not have to be made before Medicaid eligibility is approved. Providers may bill a beneficiary for services rendered after a claim rejects for lack of Medicaid eligibility.
- **For Practitioner invoice types:** Reduce amount of providers charges by the Spend-down amount in Form Locator 24F of the service line. (Per the chapter Billing & Reimbursement for Professionals Section 6-Special Billing (6.2 3rd Party Coverage)).

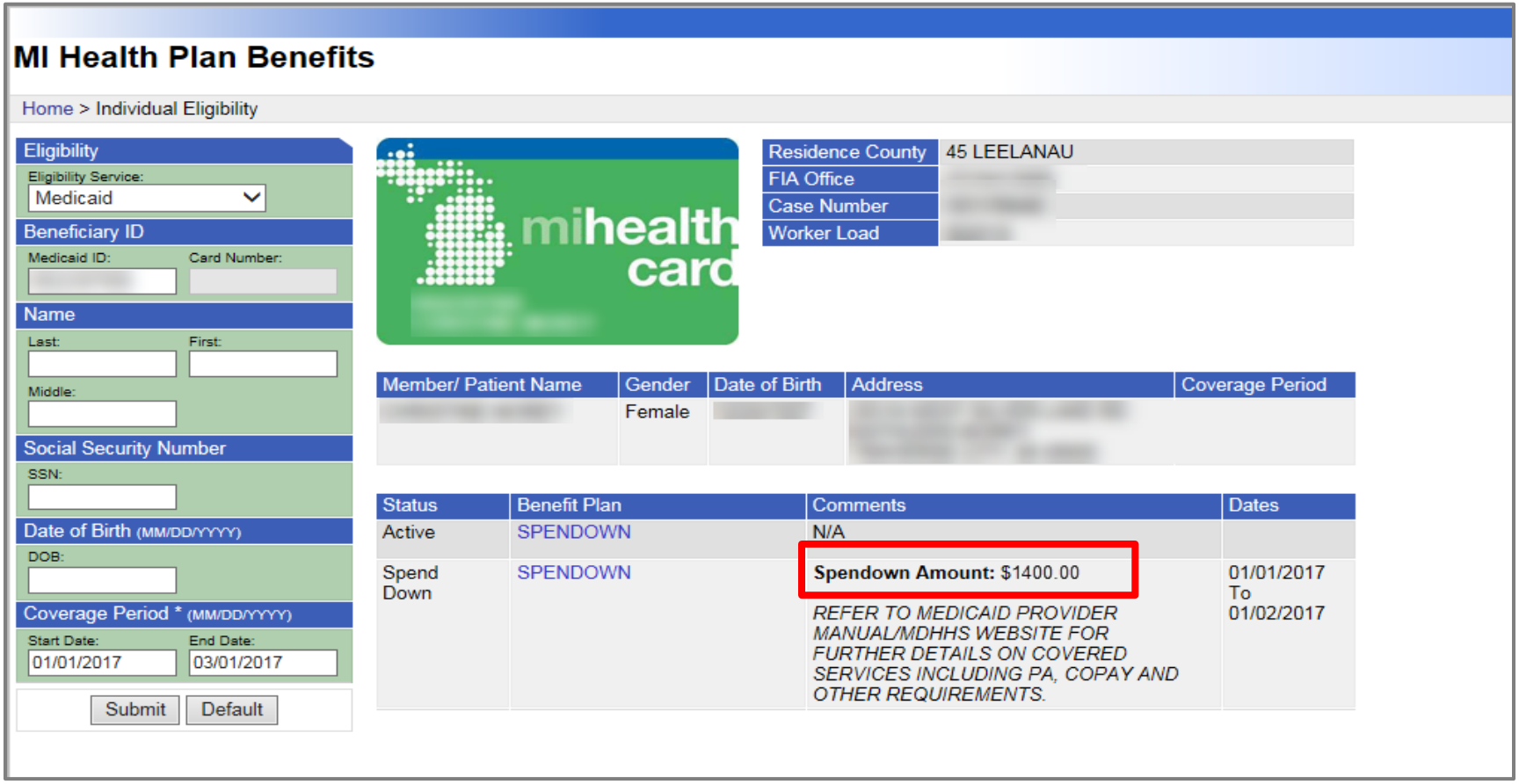
Verifying Monthly Spend-down Amount

Website Resources

Website Resources

- Spend-down https://healthplanbenefits.mihealth.org
- Displays the Spend-down amount in the eligibility response on the MI Health Plan Benefits page.
- The information is yesterday's information because the eligibility file is sent nightly from BRIDGES.
- The Spend-down amount will be displayed in the eligibility response on the 'MI Health Plan Benefits' page and with 270/271 transaction.

Website Resources (cont.)



MI Health Plan Benefits

Home > Individual Eligibility

Eligibility

Eligibility Service: Medicaid

Beneficiary ID

Medicaid ID: [redacted] Card Number: [redacted]

Name

Last: First: Middle:

Social Security Number

SSN:

Date of Birth (MM/DD/YYYY)

DOB:

Coverage Period * (MM/DD/YYYY)

Start Date: 01/01/2017 End Date: 03/01/2017

Submit Default

mihealth card

Residence County	45 LEELANAU
FIA Office	[redacted]
Case Number	[redacted]
Worker Load	[redacted]

Member/ Patient Name	Gender	Date of Birth	Address	Coverage Period
[redacted]	Female	[redacted]	[redacted]	

Status	Benefit Plan	Comments	Dates
Active	SPENDOWN	N/A	
Spend Down	SPENDOWN	**Spendown Amount:** $1400.00 *REFER TO MEDICAID PROVIDER MANUAL/MDHHS WEBSITE FOR FURTHER DETAILS ON COVERED SERVICES INCLUDING PA, COPAY AND OTHER REQUIREMENTS.*	01/01/2017 To 01/02/2017

- The Spend-down amount per the DHHS county worker for current month only.

Document Management Portal (DMP)

Allows up to 5 attachments per upload

Allows up to 30MB per attachment

Document Management Portal (DMP)

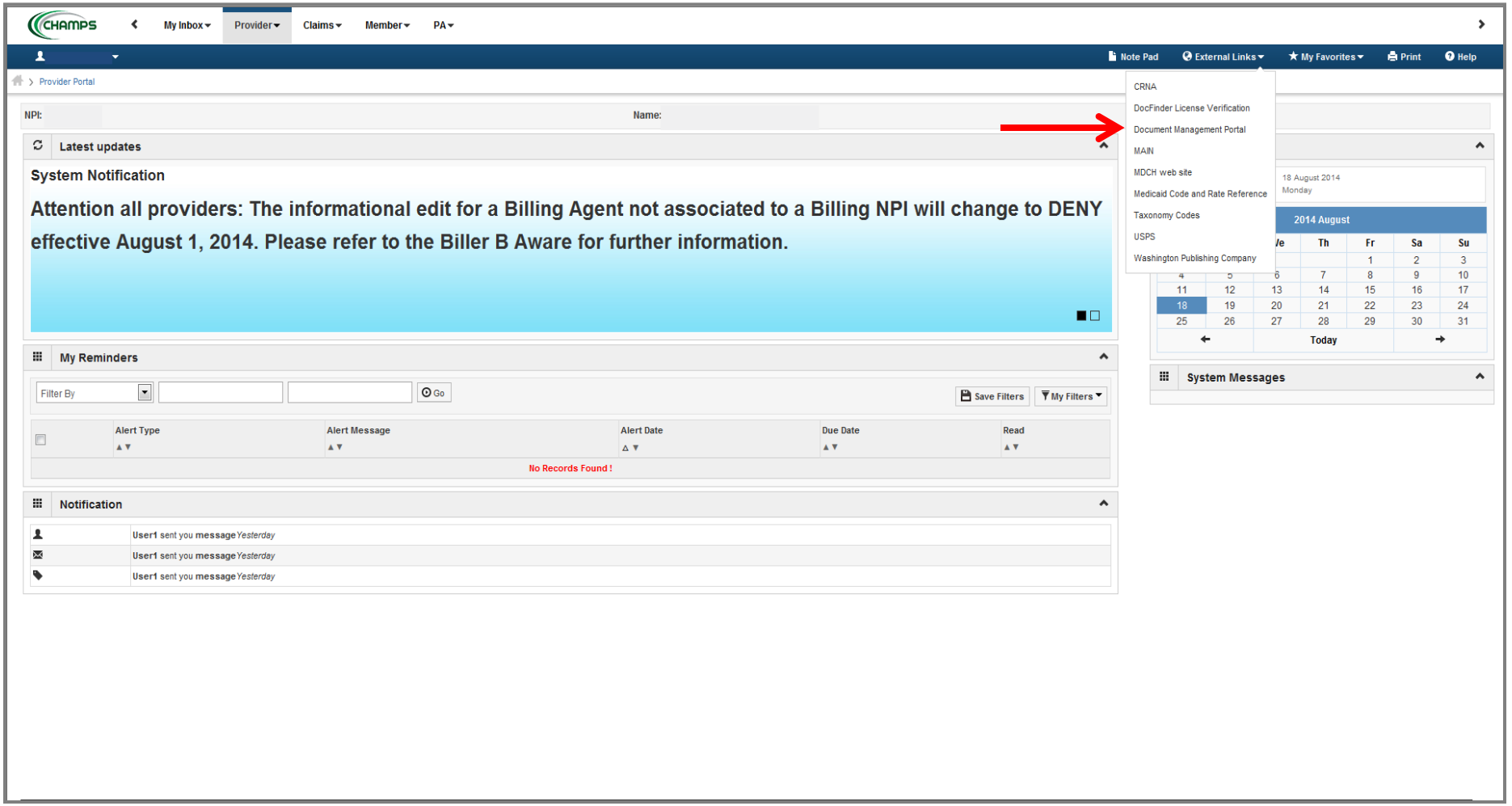
- The Document Management Portal (DMP) provides a browser-based interface to perform various tasks pertaining to submission of documents to Michigan Medicaid.
- DMP has replaced EZ Link for submitting documentation.
- DMP is authenticated via MILogin.

Document Management Portal (DMP) (cont.)

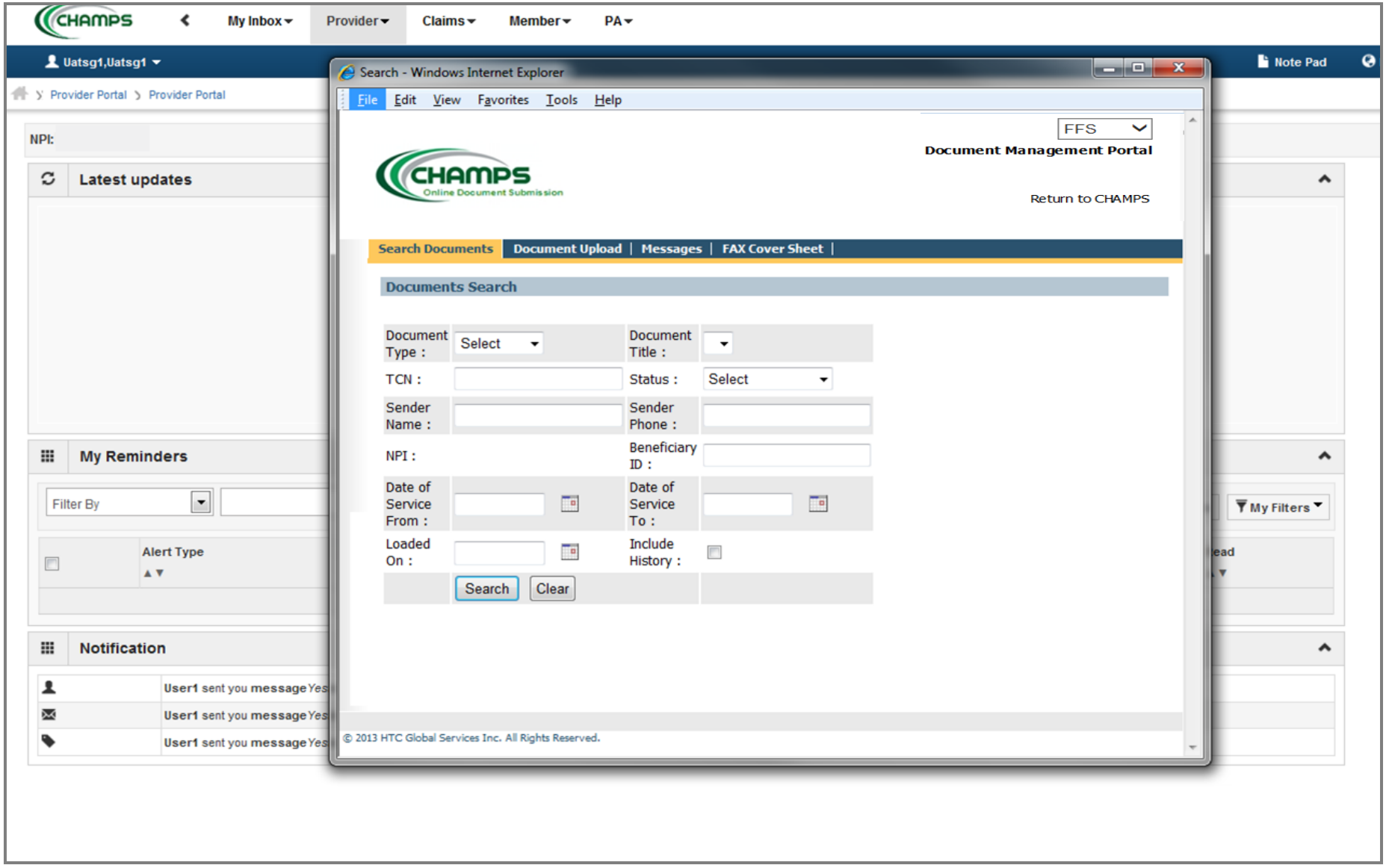
- By directly accessing DMP, providers can submit Medicaid documents that may or may not be related to a TCN.
- Users accessing the DMP will be able to:
  - Directly upload documents
  - Create cover sheets to fax in documentation
  - Search existing uploaded documents
  - Send and receive messages pertaining to submitted documents
  - View documents and associated correspondence history
  - Submit supporting documents for a procedure code, Predictive Modeling
  - Submit documents for authorization and approval, such as consents
  - View document notifications within CHAMPS
  - Receive notifications when documents are approved or denied

Document Management Portal (DMP) (cont.)

- When uploading documentation
  - A maximum of 5 attachments can be added per upload
  - A maximum of 30MB per attachment
- When uploading documents make sure to:
  - Select the correct document type
  - Select the appropriate document title
  - Have the contact person for your facility be the one uploading/ or enter the correct contact person information.
  - Include all required documents, specifically for Predictive Modeling



- Click on Document Management Portal in the External Links drop-down.
- DMP will launch in a new window. It is possible to work within DMP and CHAMPS simultaneously. DMP remains open until closed. To close DMP you will click the red X in the corner to return to Champs.



- DMP will open a new window when Document Management Portal is selected. Tabs located at the top of the page are used to navigate features within DMP.

Reminders

Reminders

- Claim status checks need to be done via CHAMPS
  - Remittance Advices can be found via CHAMPS under the My Inbox tab >> Archived Documents
  - Washington Publishing Company
- When emailing ProviderSupport@Michigan.gov please include as much information regarding your inquiry as possible. Including your Billing Provider NPI.

Reminders (cont.)

- Sending in hard copy mail inquires
  - Should not be sent for the following:
    - Claim Status questions
    - Claim inquiry questions
    - Beneficiary Eligibility request
    - Timely Filing Requests
- When hard copy mail is acceptable
  - Appeals, if the provider feels an appeal is necessary please refer to the Medicaid Provider Manual within the provider specialty chapter under the appeal section.

Reminder – Appeals

- To initiate the appeal process:
  - Provider must contact Provider Support
    - ProviderSupport@michigan.gov
    - 1-800-292-2550
  - Appeal will be directed to the appropriate Provider Consultant as necessary.
  - Provider Consultant will research and attempt to resolve the inquiry. If a resolution cannot be reached, the provider will be provided appeal rights and information.
- To inquire about a Department action:
  - Contact Provider Support by phone or email, and provide the representative with the Service Request (SR) number previously assigned.
  - If the issue/claim is not resolved to the satisfaction of the provider, the provider may appeal the Department action per the MDHHS Medicaid Provider Review and Hearing Rules.

Reminder – Consents

- MSA 1959 and MSA 2218
- Per the Medicaid Provider Manual,
  - Chapter Practitioner, Section 2: By federal statute, all services, including anesthesia services related to hysterectomies or sterilization procedures, must be supported by an informed consent that meets Medicaid's consent requirements before the service can be covered. It is the responsibility of the operating surgeon to obtain this consent.
  - Chapter Hospital, Section 3: Physicians are responsible for obtaining the signed Consent for Sterilization (MSA-1959/HHS-687) 30 days prior to surgery.
  - Chapter Hospital, Family Planning, Section 4: Consent forms (Consent for Sterilization [MSA-1959/HHS-687] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) must be submitted through the Document Management Portal.

Provider Resources

- **MDHHS website:** www.michigan.gov/medicaidproviders

- **We continue to update our Provider Resources, just click on the links below:**
  - Listserv Instructions
  - Medicaid Alerts and Biller “B” Aware
  - Quick Reference Guides
  - Update Other Insurance NOW!
  - Medicaid Provider Training Sessions

- **Provider Support:**
  - ProviderSupport@michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program