



MEDICAID PROVIDER MANUAL OVERVIEW

SECTION 1 – INTRODUCTION

The following documents comprise the Michigan Medicaid Provider Manual, and address all health insurance programs administered by the Michigan Department of Community Health (MDCH). MDCH also issues periodic bulletins as changes are implemented to the policies and/or processes described in the manual. An inventory of these bulletins is maintained in the Supplemental Bulletin List located on the MDCH website. Bulletins are incorporated into the online version of the manual on a quarterly basis. (Refer to the Directory Appendix for website information.)

1.1 ORGANIZATION [CHANGES MADE 4/1/05]

The following table identifies each chapter and appendix in the manual, indicates what providers are affected, and provides a brief overview of each.

CHAPTER TITLE	AFFECTED PROVIDERS	CHAPTER CONTENT
GENERAL PROVIDER CHAPTERS		
Medicaid Provider Manual Overview	All Providers	Brief discussion of the organization of the manual and effectively using the document.
General Information for Providers	All Providers	Policies and general information regarding provider enrollment and participation, prior authorization, record retention, billing the beneficiary, fraud and abuse, etc.
Beneficiary Eligibility	All Providers	Policies and information regarding how to verify beneficiary eligibility, information on various eligibility categories, enrollment in contracted health plans, beneficiary utilization control, etc.
Coordination of Benefits	All Providers	Policies and information regarding coordination of benefits, Medicaid's payment liability, etc.
Billing & Reimbursement for Dental Providers	Providers billing the ADA-2000 or 837 Dental claim formats.	Policies and instructions for billing dental services. Until further notice, coverage of dental services for beneficiaries age 21 and older is restricted. See the Dental Chapter for additional information.
Billing & Reimbursement for Institutional Providers	Providers billing the UB-92 or 837 Institutional claim formats.	Policies and instructions for billing institutional services.
Billing & Reimbursement for Professionals	Providers billing the CMS-1500 or 837 Professional claim formats.	Policies and instructions for billing professional services.



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CHAPTER TITLE	AFFECTED PROVIDERS	CHAPTER CONTENT
PROVIDER/SERVICE SPECIFIC CHAPTERS		
Adult Benefits Waiver	All Providers	Information regarding program eligibility, benefit package, County Health Plans, billing instructions, etc.
Ambulance	Ambulance (PT 18)	Coverage policy related to emergency and non-emergency transports by ground, water or air ambulance.
Children's Special Health Care Services	All Providers	Information regarding program eligibility, benefit package, etc.
Chiropractor	Chiropractor (PT 14)	Coverage policy related to chiropractic services.
Dental	Dentists/Dental Clinics (PT 12, 74)	Coverage policy related to dental services and information on the Healthy Kids Dental Program. Until further notice, coverage of dental services for beneficiaries age 21 and older is restricted. See the Dental Chapter for additional information.
Family Planning Clinics	Title X clinics (PT 23)	Coverage policy related to family planning services provided through Title X clinics.
Federally Qualified Health Centers	Clinics designated by HHS as FQHCs	Coverage and reimbursement policies applicable to FQHCs.
Hearing Aid Dealers	Hearing Aid Dealers (PT 90)	Coverage policy related to the dispensing of hearing aides and alternative listening devices, and related supplies.
Hearing & Speech Centers	Hearing & Speech Centers, Outpatient Therapy Providers (PT 40, 80) (modified 4/1/05)	Coverage policy related to hearing evaluations and speech/language services.
Home Health	Home Health (PT 15)	Coverage policy related to services provided by home health agencies.
Hospice	Hospice (PT 15)	Coverage policy related to hospice services.
Hospital	Inpatient & outpatient hospitals (PT 22, 30, 40)	Coverage policy for inpatient and outpatient hospital services. Also includes cost reporting requirements, Graduate Medical Education and disproportionate share payment methodologies, appeals, etc.
Laboratory	Independent Clinical Labs (PT 16)	Coverage policy for laboratory services.
Local Health Departments	Local Health Departments	Coverage policy, cost reporting requirements, interim payments, and appeals for local health departments.
Maternal & Infant Support Services	Certified MSS/ISS providers (PT 77)	Provider certification requirements, beneficiary eligibility criteria, and covered services.
Maternity Outpatient Medical Services	Providers of Maternity Related Services	Program eligibility requirements, benefit package, and billing instructions.



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CHAPTER TITLE	AFFECTED PROVIDERS	CHAPTER CONTENT
Medicaid Health Plans	Contracted HMOs (PT 17)	Health plan participation and coverage policies
Medical Supplier	Medical Suppliers/Durable Medical Equipment, Orthotists/Prosthetists (PTs 85, 87)	Coverage policies and parameters for medical supplies, durable medical equipment, orthotics, and prosthetics.
Mental Health/Substance Abuse	Mental Health and Substance Abuse providers (PT 77, 21)	Coverage policies and reporting requirements for services provided through Prepaid Inpatient Health Plans. Includes Children's Home and Community Based Services Waiver, Substance Abuse and Habilitation/Supports Waiver information.
Nursing Facility (added 4/1/05)	Nursing Facilities (PTs 60, 61, 62, 63, 64, 72)	Coverage policy; certification, survey and enforcement policy; reimbursement methodology; and appeals related to nursing facilities.
Program of All Inclusive Care for the Elderly (PACE) (added 4/1/05)	Contracted PACE providers	Information regarding program eligibility, benefit package, etc.
Pharmacy	Pharmacies (PT 50)	Coverage policy related to pharmacy services.
Practitioner	MD, DO, Oral Surgeons, DPM, NP, CRNA, CNM, Physical Therapists (PTs 10, 11, 13, 77)	Coverage policy for services rendered by physicians, advanced practice nurses, oral surgeons, and podiatrists.
Private Duty Nursing	Independent & PDN Agency (PTs 10, 15)	Coverage policy related to private duty nursing services provided through an agency or by an independent nurse.
Rural Health Clinics	Rural Health Clinics	Coverage policy related to Rural Health Clinics.
School Based Services	Enrolled Intermediate School Districts	Coverage policy for medical services provided to students eligible under the IDEA of 1990.
School Based Services – Administrative Outreach	Enrolled Intermediate School Districts	Coverage, claiming, and billing policies related to the SBS Administrative Outreach Program.
Special Programs	All Providers	General information about MDCH health insurance programs that are not addressed elsewhere in this manual.
Therapies (Outpatient)	Outpatient Therapy Providers (PT 40)	Outpatient therapy provider participation requirements. Coverage policy information currently contained in other chapters.
Tribal Health Centers	Tribal Health Centers	Coverage policy for Tribal Health Centers, defined under the Indian Self-Determination and Education Assistance Act (Public Law 93-638 as those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS).
Vision	Ophthalmologists, Optometrists, Vision suppliers (PTs 10, 86, 94, 95)	Coverage policy for vision services and hardware.



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CHAPTER TITLE	AFFECTED PROVIDERS	CHAPTER CONTENT
APPENDICES		
Acronyms	All Providers	
Directory	All Providers	
Glossary	All Providers	
Forms	All Providers	Provides samples of forms identified in the manual and instructions for form completion, when appropriate. Providers may also download forms directly from the MDCH website.

1.2 PRINTING

MDCH will not provide a printed copy of the Provider Manual but will provide the information via compact disc (CD) to all enrolled providers and subscribers on an annual basis. (Refer to the Manual Updates Section of this chapter for additional information.)

Should the user elect to print portions of the manual for his use, please note the following:

- § The version date is noted at the bottom of each page on the left hand side. When researching policy, it is imperative that the most current version be used.
- § The page number at the bottom right hand side of each page represents the page number within that chapter, not within the whole document.
- § The name of the chapter is on the bottom of each page.
- § It is recommended that any printing be done in black and white, not color as printing in color can be very expensive. The features on each page are adequately effective in black and white.



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SECTION 2 - NAVIGATION THROUGH THE MANUAL

2.1 BROWSE CAPABILITIES

Each chapter within the manual is linked with all other manual chapters and appendices. Users can easily navigate from chapter to chapter by clicking on the bookmark navigation keys located on a palette on the left side of the screen. (See the following illustrations.) To jump to a topic using its bookmark, click the bookmark icon or text in the palette that represents that topic. The bookmarks in the manual correspond to chapter titles, section titles, subsections and appendices.

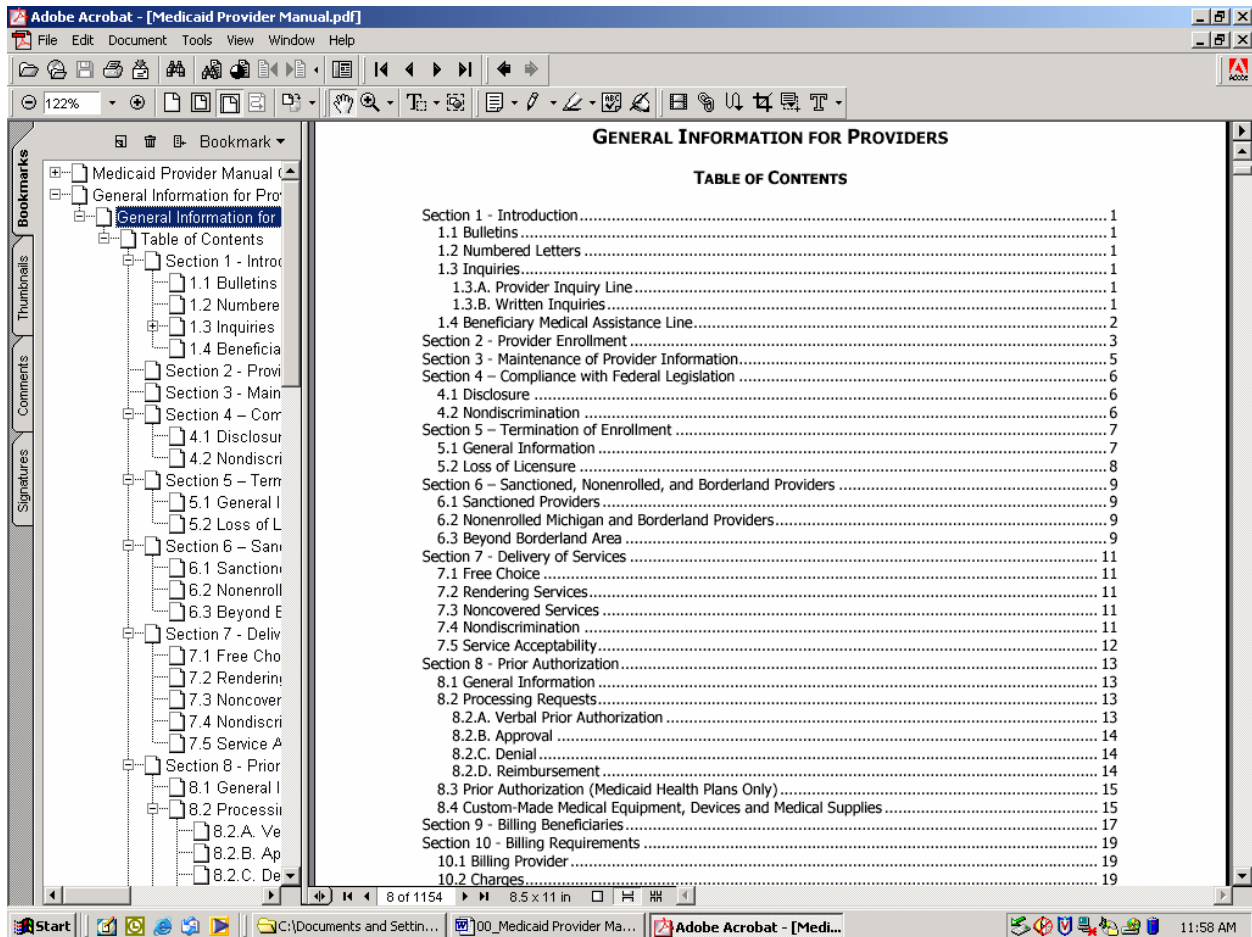
Bookmarks can be expanded or collapsed to easily link to the desired information. Primary headings, such as chapter titles, display as the first level of bookmarks. If a primary heading has secondary headings (i.e., section titles, subsections), they are displayed underneath the primary heading. Primary headings can be collapsed to hide the secondary headings. When a primary heading is collapsed, it has a plus (+) sign next to it. Click on the plus (+) sign to expand the bookmarks to display secondary headings. When all headings are displayed a minus (-) sign appears next to the heading. (See the illustrations below.)

The screenshot shows the Adobe Acrobat interface with the Medicaid Provider Manual Overview page. The bookmark palette on the left lists various sections, including 'Medicaid Provider Manual', 'General Information for Providers', 'Beneficiary Eligibility', 'Coordination of Benefits', and 'Billing & Reimbursement for Dental Providers'. The main content area displays the 'MEDICAID PROVIDER MANUAL OVERVIEW' and 'SECTION 1 - INTRODUCTION'. Below the introduction text is a table with three columns: CHAPTER TITLE, AFFECTED PROVIDERS, and CHAPTER CONTENT.

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Billing & Reimbursement for Institutional Providers	Providers billing the UB-92 or 837 Institutional claim formats.	Policies and instructions for billing institutional services.



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Users can also navigate from section to section within each chapter by clicking on the Section Titles within the Table of Contents.

2.2 SEARCH CAPABILITIES

Users can also access the powerful online search capabilities of Adobe Acrobat to quickly locate information within the manual. There are two search methods:

- § Click on Edit, Find on the tool bar and enter a keyword in the Find dialog box, or
- § Click on the Binoculars on the toolbar and enter a keyword in the dialog box.

Always use the most specific term or acronym for the search, rather than a general term. (Refer to the Acronym Appendix for a list of all those used in the manual.) Start the search on the first page of the manual to assure that all relevant information is located.

In order to locate all of the information pertinent to a subject, search by the acronym if the word or term has one.



SECTION 3 – MANUAL UPDATES

3.1 QUARTERLY UPDATES

The Medicaid Provider Manual located on the MDCH website is updated quarterly to reflect information that has been added, deleted or changed via policy bulletins and other communications during the previous quarter. The contact information contained in the Directory Appendix is also updated quarterly. Policy Bulletins, Databases, Numbered Letters and other important information are also located on the website.

A CD containing quarterly updates is not issued; therefore, the providers must pay close attention to written correspondence from MDCH and visit the MDCH website frequently to obtain the most recent information.

3.2 YEARLY UPDATES

A complete manual, incorporating changes issued during the previous year, is produced on CD annually and sent to all enrolled providers. The entire manual replacement is also available on the MDCH website for quick, online access. Providers are able to access the most recent manual on the MDCH website as well as previous manuals that may be needed for historical purposes. Manuals that were produced prior to January 2004 are not available online.



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SECTION 1 - INTRODUCTION

This chapter applies to all providers.

The Michigan Department of Community Health (MDCH) acts as the fiscal intermediary for several health insurance programs including Medicaid, Adult Benefits Waiver (ABW), Children's Special Health Care Services (CSHCS), the Refugee Assistance Program (RAP), Maternity Outpatient Medical Services (MOMS), and the Repatriate Program. Although coverage, limitations, and administration may differ, billing procedures and reimbursement methods are essentially the same.

This chapter is used for all health insurance programs administered by MDCH. Any reference to Medicaid in the manual and bulletins pertains to all programs administered by MDCH unless specifically stated otherwise. Reference to the state mental health facilities includes only those facilities owned and operated by MDCH. It does not include proprietary facilities for the mentally ill or developmentally disabled.

1.1 BULLETINS

This manual is the provider's primary source of information. Revisions to the manual regarding policy and procedural changes are sent to the provider via Policy Bulletins. Bulletins should be kept until the information is incorporated into the manual. Bulletins are numbered for the provider's reference. The first two digits of the bulletin number refer to the year. The next two digits refer to the specific sequence number assigned to the bulletin (e.g., 03-04).

Bulletins are sent to affected providers and are posted on the MDCH website. (Refer to the Directory Appendix for website and contact information.)

1.2 NUMBERED LETTERS

The purpose of a numbered letter is to educate, inform, and/or clarify issues related to MDCH policies, procedures, and/or decisions that affect multiple providers.

1.3 INQUIRIES

MDCH has several methods of resolving inquiries. Questions regarding policies and procedures should be directed to Provider Inquiry. (Refer to the Directory Appendix for contact information.)

1.3.A. PROVIDER INQUIRY LINE

If billing assistance is required, the Provider Inquiry Line is available for immediate resolution of inquiries. (Refer to the Directory Appendix for contact information.)

1.3.B. WRITTEN INQUIRIES

Complex problems may require research and analysis. The problem should be clearly explained, in writing, with complete documentation (e.g., RA) attached and sent to Provider Inquiry.



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1.4 BENEFICIARY MEDICAL ASSISTANCE LINE

If assistance to the beneficiary is required, the Beneficiary Helpline is available to assist them. (Refer to the Directory Appendix for contact information.) Beneficiaries enrolled in a Medicaid Health Plan (MHP) should be referred to their plan for assistance. Plan member services contact information is included on the beneficiary's plan membership card.

Within the limits of Medicaid, MDCH does not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, political beliefs, or source of payment.

1.5 REPORTING FRAUD AND ABUSE

Any provider, beneficiary, or employee who suspects Medicaid fraud or abuse is encouraged to report that information to MDCH. Information about fraud and abuse reporting requirements is located on the MDCH website. (Refer to the Directory Appendix for website and contact information.)

1.6 PROVIDER LIAISON MEETINGS

MDCH routinely schedules meetings to meet with provider specialty groups (e.g. physicians, hospitals, pharmacies, etc.) to discuss issues of interest/concern. The meetings are arranged through the various provider professional associations, though all affected providers and interested parties are welcome to attend. A calendar of provider liaison meetings is posted on the MDCH website, along with contact information. (Refer to the Directory Appendix for website and contact information.)



SECTION 2 - PROVIDER ENROLLMENT

An eligible provider who complies with all licensing and regulation laws applicable to the provider's practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction, and whose services are directly reimbursable per MDCH policy, may enroll as a Medicaid provider. Borderland providers and, under certain circumstances, beyond-borderland providers must be licensed and/or certified by the appropriate standard-setting authority in their home state. (Refer to the Beyond-Borderland Area Section of this chapter for more information.) In addition, some providers must also be certified as meeting Medicare or other standards as specified by MDCH.

Providers must have a completed and signed Medical Assistance Provider Enrollment & Trading Partner Agreement (DCH-1625) on file with the Provider Enrollment Unit to be reimbursed for covered services rendered to eligible Medicaid beneficiaries.

A provider's participation in Medicaid is effective on the date the provider signs the DCH-1625 if the Provider Enrollment Unit receives the application within 30 calendar days of the signature date. If the application/agreement is not received within 30 calendar days of the signature date, the provider's enrollment is effective on the date it is received and date-stamped by the Provider Enrollment Unit.

Providers may request, in writing, that enrollment be retroactive. The request should be addressed to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

Retroactive enrollment is not considered prior to the effective date of licensure/certification or provider reinstatement. Enrollment may be retroactive one year from the date the request is received if the provider's licensure/certification or reinstatement is effective for that entire period. Retroactive enrollment eligibility is not a waiver for claims/services that do not meet established Medicaid billing criteria.

Once enrolled, providers are sent the MDCH Provider Confirmation Form. This is a computer printout of data on file with the Provider Enrollment Unit. Corrections to the data should be directed to the Provider Enrollment Unit. The form is not to be returned to MDCH.

The Provider Enrollment Unit does not issue a group or corporate provider identification (ID) number for multiple provider practices or multi-site or agency entities. Each provider (e.g., physician, dentist, etc.) within a group must enroll as a Medicaid provider. Each service rendered by a provider in a group must be billed using that provider's individual ID number. If a provider renders services at several service office locations/sites, the provider must have a separate ID number identifying each individual service location/site. A service office location/site is defined as a physical facility where a provider conducts business operations. The facility and its operations would include:

- § Seeing patients;
- § Maintaining staff;
- § Having established hours; and
- § Storage of medical records.

If a provider does not normally practice in an office (e.g., anesthesiologist), then separate ID numbers are not required.



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For information regarding substitute physician or a locum tenens arrangement, refer to the Practitioner Chapter of this manual.

A Medicaid Health Plan (MHP) is responsible for reimbursing a contracted provider or subcontractor for its services according to the conditions stated in the subcontract. The MHP must also reimburse noncontracted providers for properly authorized, medically necessary covered services.



SECTION 3 - MAINTENANCE OF PROVIDER INFORMATION

Providers must notify the MDCH Provider Enrollment Unit immediately, in writing, of changes affecting their enrollment information. (Refer to the Directory Appendix for contact information.)

Examples of such changes include:

- § A change in the provider's Federal Employer ID Number (or Tax ID Number).
- § Moving to a new office.
- § Adding another office or location.
- § Leaving the current employer/partnership.
- § Changing the billing address to which warrants and RAs only are sent.
- § Retiring from practice.
- § Closing a business.
- § Provider files Chapter 11, Reorganization.
- § Provider files Chapter 7, Bankruptcy.
- § Any action taken by a licensing authority or hospital that affects health care privileges.
- § Any criminal conviction.
- § Addition/change of a specialty (a copy of the Letter of Congratulations or a certificate is required).
- § Employer/partnership additions or changes.
- § Change/loss of licensure status.
- § New employees/providers.
- § New contractual obligations to a clinic, employer, contractor, or other entity.
- § Clinical Laboratory Improvement Act (CLIA) changes.
- § A change in ownership.

Nursing Facility providers should refer to the Nursing Facility Chapter for additional instructions.

Some of these changes may result in termination or a change in the provider ID number. Failure to notify MDCH of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.

The Provider Enrollment Unit disenrolls providers if mail is returned as nondeliverable.



SECTION 4 – COMPLIANCE WITH FEDERAL LEGISLATION

4.1 DISCLOSURE

Providers must notify the state-licensing agency and MDCH Provider Enrollment of any person(s) with an ownership or controlling interest in a facility that has been convicted of a criminal offense related to their involvement in any programs under Medicare, Medicaid, or Social Services Block Grants since the inception of these programs.

4.2 NONDISCRIMINATION

Federal regulations require that all programs receiving federal assistance through Health and Human Services (HHS) comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Providers are prohibited from denying services or otherwise discriminating against any medical assistance recipient on the grounds of race, color, national origin or handicap. For complaints of noncompliance, contact the Michigan Department of Civil Rights or the Office of Civil Rights within the U.S. Department of Justice. (Refer to the Directory Appendix for contact information.)



SECTION 5 – TERMINATION OF ENROLLMENT

5.1 GENERAL INFORMATION

The name of any provider or provider organization suspected of fraudulent practices, misuse or abuse of protected health information in relation to Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements or suspected of accepting or soliciting unearned rebates, refunds, receipt of free goods, or other unearned considerations, in the form of money or otherwise, is referred to the Office of Civil Rights, the Department of Attorney General or to the Office of the United States Attorney General for investigation and possible prosecution under applicable state and/or federal statutes. In the event of a disqualifying action (e.g., loss of license or certification, suspension or exclusion), providers are immediately terminated from participation in Medicaid on the effective date of the disqualifying action.

The following are considered grounds for termination or refusal to renew the provider's participation in Medicaid:

- § Any actions that threaten the health, safety, or welfare, or privacy of protected health information of Medicaid beneficiaries.
- § Any actions that threaten the fiscal integrity of Medicaid.
- § Violation of contractual obligations.
- § Continued failure to correct cited inappropriate services or billing actions.
- § Failure to comply with the conditions of participation.
- § Abuse of patient trust funds (Nursing Facilities only).
- § Failure to meet certification standards.
- § A pattern of providing inappropriate or unnecessary services to a beneficiary.
- § Termination or exclusion from the Medicare Program.
- § Conviction under Medicaid or Health Care False Claim Act or similar state/federal statute.

Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS.)

If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDCH considers it as a basis for summary suspension:

- § An evaluation of billing practices.
- § The prior authorization (PA) process.
- § An on-site review of financial and medical records and a written report of this review is filed.
- § The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider.
- § A peer review of services or practices.



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- § A hearing or conference between MDCH and the provider (and counsel, if so requested).
- § Indictment or bindover on charges under the Medicaid or Health Care False Claim Act or similar state/federal statute.

5.2 LOSS OF LICENSURE

For providers who must be licensed to practice their profession, continued enrollment in Medicaid is dependent upon maintaining licensure. Failure to renew a provider's license results in disenrollment from Medicaid effective the date of final lapse of the provider's license.

Suspension or revocation of a provider's license by the appropriate standard setting authority results in termination of Medicaid participation effective on the date the provider is no longer licensed. In the case of a provider not located in Michigan, suspension or revocation would be administered by the appropriate state licensing board.

If a provider is no longer licensed to practice (e.g., the license was suspended, lapsed, or revoked), MDCH does not reimburse for services rendered or ordered by that provider after the termination of the license. Medicaid payments obtained for services rendered during a period when the provider was unlicensed must be refunded to the State.

A provider may contact the Provider Enrollment Unit, in writing, to request re-enrollment as a Medicaid provider when his license is reinstated.



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SECTION 6 – SANCTIONED, NONENROLLED, AND BORDERLAND PROVIDERS

6.1 SANCTIONED PROVIDERS

Medicaid does not reimburse providers for any services rendered that were ordered/prescribed by sanctioned (suspended, terminated or excluded) providers. If a provider is presented with an order/prescription from a sanctioned provider, that provider should inform the beneficiary that the order/prescription cannot be filled because the ordering/prescribing provider has been suspended from Medicaid. The beneficiary may purchase the service if he understands why the service is not covered by Medicaid and agrees, in writing, to pay for the service.

Notice of a provider's sanction is issued in Medicaid Bulletins. In order to ensure providers receive timely notification regarding sanctioned providers, a notifying bulletin, including a cumulative list of sanctioned providers, is printed twice a year. Other qualifying bulletins showing additions and deletions to the sanctioned provider list are issued on a monthly basis. A copy of the cumulative list is also available on the MDCH website at the address noted in the Directory Appendix.

Providers should check each name on the list closely to avoid accepting orders/prescriptions for Medicaid beneficiaries from these sanctioned providers. The list is also distributed to providers and to the Department of Human Services (DHS) county offices each time a provider is sanctioned as a result of Medicaid initiating the sanction.

The Bulletin also includes providers who have been sanctioned by other programs (e.g., Medicare). If the source has suspended, terminated, or excluded a provider from participation, that action remains applicable to Medicaid even if that provider has not been included on Medicaid's list of sanctioned providers. Any payments that may be unintentionally made to a provider acting on an order/prescription from a sanctioned provider, for dates of service on or after the dates indicated on the list, must be refunded to Medicaid.

6.2 NONENROLLED MICHIGAN AND BORDERLAND PROVIDERS [CHANGE MADE 7/1/05 & 10/1/05]

Medicaid pays nonenrolled Michigan and nonenrolled borderland providers for emergency services and for the first claim for nonemergency services that were provided in compliance with Michigan Medicaid coverage policies. (added for clarification 7/1/05)

All nonenrolled Michigan and borderland providers rendering services to Michigan Medicaid beneficiaries must have a signed DCH-1625, Medical Assistance Provider Enrollment & Trading Partner Agreement on file with the MDCH in order to receive reimbursement. Providers that choose not to enroll as a Michigan Medicaid provider may enter into a "trading partner only" arrangement with the MDCH by including that statement on the DCH-1625. If selecting this option, providers must contact MDCH Provider Inquiry (changed 10/1/05) for billing instructions. (Refer to the Directory Appendix for contact information.) Claims submitted through Provider Inquiry (changed 10/1/05) will experience significant delays in processing. Providers should contact the MDCH Provider Enrollment Unit to obtain a copy of the DCH-1625. (Refer to the Directory Appendix for contact information.)

When a nonenrolled Michigan and borderland provider submits a claim for nonemergency services, Provider Inquiry (changed 10/1/05) will process the claim and sends a letter to the provider with an enrollment application inviting him to enroll in Medicaid. If the provider elects not to enroll in Medicaid



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and submits another claim(s) for nonemergency services for payment, **Provider Inquiry (change 10/1/05)** returns the claim(s) with another application for enrollment. This second invitation to enroll states that if the provider chooses not to enroll, the claim(s) will not be paid. The provider and the beneficiary must then make their own payment arrangements for the service(s).

6.3 BEYOND BORDERLAND AREA [CHANGE MADE 10/1/05]

Reimbursement for services rendered to beneficiaries is normally limited to Medicaid-enrolled providers. MDCH reimburses nonenrolled providers who are beyond the borderland area if the service meets one of the following criteria:

- § Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Balanced Budget Act of 1997 and its regulations; or
- § Medicare has paid a portion of the service and the provider is billing MDCH for the coinsurance and/or deductible amounts; or
- § The service is prior authorized by MDCH.

Providers must be licensed and/or certified by the appropriate standard-setting authority.

All providers rendering services to Michigan Medicaid beneficiaries must have a signed DCH-1625 Medical Assistance Provider Enrollment & Trading Partner Agreement on file with the MDCH in order to receive reimbursement. Out of state providers should contact the MDCH Provider Enrollment Unit to obtain a copy of the DCH-1625. (Refer to the Directory Appendix for contact information.)

Out of state providers enrolled with the Michigan Medicaid program may submit their claims directly to the MDCH billing system. Providers should refer to the appropriate Billing and Reimbursement chapter of this manual for billing instructions.

Providers that choose not to enroll as a Michigan Medicaid provider may enter into a "trading partner only" arrangement with the MDCH by including that statement on the DCH-1625. If selecting this option, providers must contact **MDCH Provider Inquiry (changed 10/1/05)** for billing instructions. (Refer to the Directory Appendix for contact information.) Claims submitted through Provider Inquiry will experience significant delays in processing.

Nonenrolled providers have a responsibility to follow Michigan Medicaid policies, including obtaining PA for those services that require PA by enrolled Michigan providers.

All nonemergency services rendered by providers require the referring physician to obtain written PA from MDCH as indicated in the Prior Authorization Section of this chapter.

When a Michigan provider has referred a Medicaid beneficiary to a provider beyond the borderland area, the referring provider should instruct the provider to contact the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)



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Borderland is defined as a county that is contiguous to the Michigan border. It also includes the five major cities beyond the contiguous county lines. The borderland area includes:

Indiana	Fort Wayne (city); Elkhart, LaGrange, LaPorte, St. Joseph, and Steuben (counties)
Ohio	Fulton, Lucas, and Williams (counties)
Wisconsin	Ashland, Green Bay, and Rhinelander (cities); Florence, Iron, Marinette, Forest, and Vilas (counties)
Minnesota	Duluth (city)



SECTION 7 - DELIVERY OF SERVICES

7.1 FREE CHOICE

Beneficiaries are assured free choice in selecting an enrolled licensed/certified provider to render services, unless they are patients in a state-owned and-operated psychiatric facility or enrolled in a MHP or County Health Plan (CHP) (including PLUS CARE).

7.2 RENDERING SERVICES

Enrollment in Medicaid does not legally require a provider to render services to every Medicaid beneficiary seeking care, except as noted below. Providers may accept Medicaid beneficiaries on a selective basis. However, a Medicare participating provider must accept assignment for Medicare and Medicaid dual eligibles.

Hospitals must provide emergency services as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42USC 1395dd.

If a Medicaid-only beneficiary is told and understands that a provider is not accepting them as a Medicaid patient and asks to be private pay, the provider may charge the patient for services rendered. The beneficiary must be advised prior to services being rendered that his **mihealth** card is not accepted and that they are responsible for payment.

All such services rendered must be in compliance with the provider enrollment agreement; contracts (when appropriate); Medicaid policies; and applicable county, state, and federal laws and regulations governing the delivery of health care services. (Refer to the Billing Beneficiary Section of this chapter for more information.)

7.3 NONCOVERED SERVICES

When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangements for that noncovered service. The beneficiary must be informed, prior to rendering of service, that Medicaid does not cover the service. A Medicaid beneficiary in a nursing facility can use his patient-pay funds to purchase noncovered services subject to MDCH verification of medical necessity and the provider's usual and customary charge. (Refer to the Nursing Facility Chapter for more information.)

7.4 NONDISCRIMINATION

Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment.



7.5 SERVICE ACCEPTABILITY

MDCH may determine that a provider did not render services within the scope of currently accepted medical/dental practice or the service was not provided within Medicaid limitations. In such cases, MDCH reviews the situation and may:

- § Refuse to reimburse for the service.
- § Require the provider to repeat or correct the service at no additional charge to Medicaid or the beneficiary (e.g., an inaccurate vision prescription was written).
- § Recover any monies paid to the provider for the service.
- § Require the service to be done immediately (e.g., provide services to complete an incomplete examination or treatment).

Failure to comply with any of the last three items may result in the provider's disenrollment from Medicaid.



SECTION 8 - PRIOR AUTHORIZATION

8.1 GENERAL INFORMATION

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization (PA). In order for Medicaid to reimburse the provider in this situation, MDCH requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific chapter for PA requirements. (Refer to the Directory Appendix for contact information for PA.)

Requests for PA may be submitted in writing, or electronically (utilizing the ANSI X12N 278 version 4010A1 Health Care Services Review/Request transaction) if the provider is an MDCH-approved EDI submitter. Providers wishing to submit a 278 transaction should refer to the Electronic Submission Manual and the MDCH Companion Guide for the HIPAA 278 Health Care Services Review/Request transaction for further information. Both documents are available on the MDCH website. (Refer to the Directory Appendix for contact information.)

PA requirements for MHP enrollees may differ from those described in this manual. Providers should contact the individual plans regarding their authorization requirements.

PA may not be required if the beneficiary has Medicare or other insurance coverage. (Refer to the Coordination of Benefits Chapter for additional information.)

8.2 PROCESSING REQUESTS

Based on documentation submitted, the PA request is approved, disapproved, or returned for more information. Results of the request are returned to the provider via a letter or a copy of the PA form, whichever is applicable. Providers must immediately notify the beneficiary of the approval or denial of the PA request.

Approval of a PA request does not verify beneficiary eligibility. It is the provider's responsibility to verify the beneficiary's eligibility for the date a service is actually rendered.

8.2.A. VERBAL PRIOR AUTHORIZATION

If a service requires PA but the situation requires immediate action to diagnose or correct a medical condition or avoid further damage, the provider may request PA by calling the MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

If the service is required at a time when MDCH cannot be contacted, the provider may perform the service and call MDCH by the end of the next working day.

After verbal authorization is obtained, the provider must submit a written PA request (with supporting documentation) to MDCH. If the supporting documentation matches the information relayed for verbal authorization, MDCH sends an approval to the provider.



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8.2.B. APPROVAL

Payment is made only for services provided during the period of time the PA is valid and the beneficiary is eligible for Medicaid. Providers should carefully review the approval as it is for specific services and may be for only a specific period of time.

The prior authorized service must be the service that is rendered and billed. If there are changes in the plan of treatment or if the approved service does not accurately reflect the service to be provided, the Prior Authorization Division should be contacted prior to rendering the service.

If a beneficiary elects to accept a service other than the service that was authorized, and that service also requires PA, which was not obtained or is not covered by Medicaid, the beneficiary is responsible for payment of the entire service. In this situation, the provider must notify the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

8.2.C. DENIAL

If PA for the service is denied, it must not be billed to Medicaid. The beneficiary will be sent a copy of the denial with an explanation of his appeal rights. Once notified of the denial, the beneficiary may still wish to receive the service. The provider must reiterate to the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

8.2.D. REIMBURSEMENT

For most providers, procedure codes that do not have an MDCH established fee screen, or need special pricing, require documentation to be sent with the claim. For some types of services, the special pricing review is completed through the PA process. If a PA is returned with an approved fee, no documentation is required with the claim. If the PA is returned without an approved fee and instructions to bill under a not otherwise classified (NOC) code, documentation must be submitted with the claim.

Medicaid does not provide reimbursement if:

- § The beneficiary was not eligible for Medicaid on the DOS. Reimbursement is denied on this basis even if the service has been prior authorized. **Exception:** For customized equipment and devices, the beneficiary must be eligible for Medicaid on the date the item/service was ordered to be eligible for reimbursement.
- § A service that is prior authorized is rendered in conjunction with a service that is not a separately reimbursable service and is not a Medicaid benefit.
- § A service that is prior authorized and rendered in conjunction with another service that requires PA, and PA for the second service was not obtained.
- § PA was required but was not obtained.



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- § Beneficiary has other insurance and the rules for coverage for other insurance were not followed.
- § It was determined that PA was obtained after the service was rendered. (The provider should refer to the Verbal Prior Authorization subsection above for an exception to this situation.)
- § The service/product was ordered or prescribed by a provider who has been sanctioned from Medicaid, and the sanction was effective before PA was granted.

Providers cannot charge the beneficiary or beneficiary's representative for the provider's failure to obtain PA. If the provider failed to obtain PA for a service and the service was rendered, he cannot apply his fee for that service in calculating other reimbursement due to him from Medicaid.

8.3 PRIOR AUTHORIZATION (MEDICAID HEALTH PLANS ONLY)

MHPs are responsible for authorizing all Medicaid-covered services in the Comprehensive Health Care Program (CHCP) benefit package for enrolled Medicaid beneficiaries, with certain exceptions such as emergency services. Providers must contact the MHPs before rendering services to MHP enrollees to obtain PA. Each MHP is responsible for establishing procedures for PA.

8.4 CUSTOM-MADE MEDICAL EQUIPMENT, DEVICES AND MEDICAL SUPPLIES

Medicaid is responsible for payment of custom equipment or devices, hearing aids, eye-glasses, dentures, prosthetics and orthotics authorized and ordered before the last date of Medicaid eligibility and delivered within 30 days after loss of eligibility. This policy also applies to enrollment changes that signify a change in payment responsibility similar to the loss of eligibility.

Medicaid or the MHP that authorizes and orders the equipment or item is responsible for paying for the item even though it is delivered after the beneficiary loses eligibility or has an enrollment change (fee-for-service [FFS] to MHP, MHP to FFS or MHP to MHP). The order must be placed before the change in enrollment status, and the service should be delivered within 30 days after the change in enrollment status.

If a provider determines that a beneficiary needs a durable medical equipment (DME) item that is authorized by either MDCH or the current MHP and is ordered before a change in enrollment status, the party that authorized the service is responsible for payment.

If a custom-made item, medical device, or equipment (e.g., prosthetic limb, custom-made medical equipment such as a brace, custom motorized wheelchair, orthotics) is ordered for a beneficiary during a hospital stay but is not delivered until after discharge and enrollment status changes, payment must be made by the party responsible for the hospital stay.

This policy does not apply to mass-produced, readily available items that can be used by a person other than for whom it was ordered. It also excludes all rental items, all expendable/disposable medical supply items (e.g., diapers, dressings, ostomy supplies, IV infusion supplies) or any item that does not require a length of time (days or weeks) to special order for a specific person.



SECTION 9 - BILLING BENEFICIARIES [CHANGE MADE 7/1/05]

Providers cannot bill beneficiaries for services except in the following situations:

- § A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
- § A monthly patient-pay amount for inpatient hospital or nursing facility services. The local DHS determines the patient-pay amount. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for more information.)
- § For nursing facility (NF), state-owned and -operated facilities or CMHSP-operated facilities determine a financial liability or ability-to-pay amount separate from the DHS patient-pay amount. The state-owned and -operated facilities or CMHSP-operated facilities liability may be an individual, spouse, or parental responsibility. This responsibility is determined at initiation of services and is reviewed periodically. The beneficiary or his authorized representative is responsible for the state-owned and -operated facilities or CMHSP ability to pay amount, even if the patient-pay amount is greater.
- § The provider has been notified by DHS 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 (changed 7/1/05)** amount.
- § If the beneficiary is enrolled in a MHP and the health plan 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 has been told prior to rendering the service that it was not covered by Medicaid. If the beneficiary is not informed of Medicaid noncoverage until after the services have been rendered, the provider cannot bill the beneficiary.
- § 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).
- § 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.

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



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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 to this policy are services/equipment (e.g., root canal therapy, dentures, customized seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for more information regarding exceptions.)

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 or for 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.

If a Medicaid-only beneficiary understands that a provider is not accepting him as a Medicaid patient and asks to be private pay, the provider may charge the beneficiary its usual and customary charges for services rendered. The beneficiary must be advised prior to services being rendered that his **mihealth** card is not accepted and that he is responsible for payment. It is recommended that the provider obtain the beneficiary's acknowledgement of payment responsibility in writing for the specific services to be provided.



SECTION 10 - BILLING REQUIREMENTS

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual.

10.1 BILLING PROVIDER

Providers must not bill MDCH for services that have not been completed at the time of the billing.

The provider who renders the service must bill for the service on the appropriate claim form using his own provider ID number for the location where the service was actually rendered.

Providers rendering services to the residents of the ICF/MR facility (Mt. Pleasant Regional Center) may not bill Medicaid directly. All covered services (e.g., laboratory, x-rays, medical surgical supplies including incontinent supplies, hospital emergency rooms, clinics, optometrists, dentists, physicians, and pharmacy) are included in the per diem rate.

10.2 CHARGES

Providers cannot charge Medicaid a higher rate for a service rendered to a beneficiary than the lowest charge that would be made to others for the same or similar service. This includes advertised discounts, special promotions, or other programs to initiate reduced prices made available to the general public or a similar portion of the population. In cases where a beneficiary has private insurance and the provider is participating with the other insurance, refer to the Coordination of Benefits Chapter of this manual for further information.

10.3 BILLING LIMITATION

Each claim received by MDCH receives a unique identifier called a Claim Reference Number (CRN). This is a ten-digit number found in the Remittance Advice (RA) that indicates the date the claim was entered into the MDCH Claims Processing (CP) System. The CRN is used when determining active review of a claim. (Refer to the Billing & Reimbursement Chapters for more information.)

A claim must be initially received and acknowledged (i.e., assigned a CRN) by MDCH within twelve months from the date of service (DOS).^{*} DOS has several meanings:

- § For inpatient hospitals, nursing facilities, and MHPs, it is the "From" or "Through" date indicated on the claim.
- § For all other providers, it is the date the service was actually rendered or delivered.

Claims over one year old must have continuous active review to be considered for Medicaid reimbursement. Claim replacement can be resubmitted within 12 months of the latest RA date or other activity.

^{*} Initial pharmacy claims (provider type 50) must be received within 180 days.



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Active review means the claim was received and acknowledged by MDCH within twelve months from the DOS. In addition, claims with DOS over one year old must be billed within 120 days from the date of the last rejection. For most claims, MDCH reviews the claims history file for verification of active review.

Only the following types of claims require documentation of previous activity in the Remarks section of the claim:

- § Claim replacements;
- § Claims previously billed under a different provider ID number;
- § Claims previously billed under a different beneficiary ID number; and
- § Claims previously billed using a different DOS, "statement covers period" for nursing facilities and inpatient hospitals.

There are occasions when providers are not able to bill within the established time frames (e.g., awaiting notification of retroactive beneficiary eligibility). In these situations, the provider should submit a claim to Medicaid, knowing the claim will be rejected. This gives the provider a CRN to document continuous active review.

Exceptions may be made to the billing limitation policy in the following circumstances.

- § Department administrative error occurred, including:
 - Ø The provider received erroneous written instructions from MDCH staff;
 - Ø MDCH staff failed to enter (or entered erroneous) authorization, level of care, or restriction on the system;
 - Ø MDCH contractor issued an erroneous PA; and
 - Ø Other administrative errors by MDCH or its contractors that can be documented.

Retroactive provider enrollment is not considered an exception to the billing limitation.

- § Medicaid beneficiary eligibility/authorization was established retroactively:
 - Ø Beneficiary eligibility/authorization was established more than twelve months after the DOS; and
 - Ø The provider submitted the initial invoice within twelve months of the establishment of beneficiary eligibility/authorization.
- § Judicial Action/Mandate: A court or MDCH administrative law judge ordered payment of the claim.
- § Medicare processing was delayed: The claim was submitted to Medicare within 120 days of the DOS and Medicare submitted the claim to Medicaid within 120 days of the subsequent resolution. (Refer to the Coordination of Benefits Chapter in this manual for further information.)



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Providers who have claims meeting either of the first two exception criteria must contact their local DHS office to initiate the following exception process:

- § The DHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038) to MDCH.
- § DHS informs the provider when the MSA-1038 has been approved by MDCH.
- § Once informed of the approval, the provider prepares claims related to the exception, indicating "MSA-1038 approval on file" in the comment section.
- § The provider submits claims to MDCH through the normal submission process.

Refer to the Billing & Reimbursement chapters of this manual for additional information on claim submission. Questions regarding claims submitted under this exception should be directed to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

10.4 PROFESSIONAL CORPORATION

For services involving multiple visits billed with a single procedure code (e.g., surgery and pre- and post-operative care, prenatal care) or initial or new services, the code/service may be billed only once by a professional corporation. Other members of the corporation may not bill separately any procedures related to the service. This policy includes services rendered in a partnership, employer-employee, or contractor relationships.

10.5 INVOICE COMPLETION FEE

A fee for completing the Medicaid claim cannot be charged to Medicaid, the beneficiary, or the beneficiary's representative.

10.6 CLAIM DOCUMENTATION

In some cases, MDCH may require specific information with the claim (e.g., indication of medical necessity). Providers should refer to the provider-specific and Billing & Reimbursement Chapters of this manual for the information that may be needed on the claim.

A claim without the requested information may be reviewed:

- § Prior to payment. (The claim may be rejected for missing, incorrect or insufficient information.)
- § Subsequent to payment. (A post-payment audit/review may indicate that the information was insufficient or missing and a gross adjustment would be initiated to recover the payment.)

10.7 CLAIM CERTIFICATION

Providers certify by signature that a claim is true, accurate, and contains no false or erroneous information. The provider's signature or that of the provider's authorized representative may be handwritten, typed, or rubber-stamped on a paper claim.

When a provider's warrant is endorsed or deposited, it is certification that the services billed were actually provided. It further certifies that the claims (paper or electronic) paid by the warrant accurately document that the health care services provided were within the limitation of Medicaid (or compliance



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with a contract). The warrant's certification applies to original claims as well as resubmitted claims and claim adjustments.

This does not apply to state-owned and -operated facilities, as they do not receive a warrant.

Providers are held responsible for any errors, omissions, or resulting liabilities that may arise from any claim for medical services submitted to MDCH under the provider's name or ID number. Contractual arrangements (verbal or written) with employers, employees, contractors, etc., do not release the provider of the responsibility for services billed or signed under the provider's ID Number.

Providers are responsible for the supervision of a subordinate, officer, employee, or contracted billing agent who prepares or submits the provider's claims.

10.8 BILLING AGENTS

A billing agent who submits Medicaid claims via electronic media must be authorized by MDCH before submitting claims. The provider must then authorize the billing agent to submit his claims. The authorization for submitting claims via electronic media must be submitted even if the provider is acting as his own billing agent. The provider must submit a completed Medicaid Billing Agent Authorization (DCH-1343) to the MDCH Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

After processing the DCH-1343, the Provider Enrollment Unit mails a confirmation letter, along with the DCH Provider Confirmation Form, to the provider. The provider must then notify the billing agent that he may begin submitting claims on the provider's behalf.

MDCH notifies providers of changes by means of bulletins and letters. If the provider has a contract with a billing service, it is the provider's responsibility to notify the billing service of any changes that may affect claims submitted on his behalf. Providers are responsible for the claims submitted by the billing agent, including improper billings, duplicate payments, etc.

In the case of a billing agent who submits electronic claims, DCH-1343 represents the provider's signature. For the billing agent who submits paper claims, the billing agent's name should appear in the certification area of the claim. If the provider wishes to have his name appear in the certification area as well, it should precede the billing agent's name.

The MDCH Electronic Submission Manual contains additional detailed information. (Refer to the Directory Appendix for website information.)



SECTION 11 - THIRD PARTY LIABILITY

Federal regulations require that all identifiable financial resources available for payment, including Medicare, be billed prior to billing Medicaid. (Refer to the Coordination of Benefits Chapter of this manual for more information.)

Medicaid does not reimburse for services provided to individuals being held in a detention facility against their will except for those directly related to an inpatient hospital stay (medical/surgical/psychiatric) provided in a nonstate owned facility. All other services must be billed to the detention facility. The Eligibility Verification System (EVS) shows Level of Care 32 for these individuals.



SECTION 12 - REIMBURSEMENT

12.1 PAYMENT IN FULL

Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by MHPs, CHPs, and PIHPs/CMHSPs/CAs for their Medicaid enrollees.

Contractors or nursing facility (including ICF/MR) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDCH ability-to-pay amount.

12.2 PRE- AND POST-PAYMENT REVIEW/AUDIT

Providers are subject to pre- and post-payment review/audit or an adjustment to the reimbursement rate.

- § In prepayment review, MDCH may deny reimbursement for a service until it is satisfied the service meets Medicaid guidelines.
- § In post-payment review/audit, MDCH may initiate an adjustment to obtain monies paid for services that do not comply with Medicaid coverage, billing and/or reimbursement policies or suspend or disenroll the provider from Medicaid.

12.3 EMERGENCY SERVICES (MHPs ONLY)

Emergency services to the point of stabilization (as required to be provided under the Emergency Medical Treatment and Active Labor Act [EMTALA]), provided to a MHP enrollee inside or outside the MHP's service area, must be reimbursed by the MHP to the provider of services.

12.4 FACTORING

Factoring of Medicaid accounts by any provider is prohibited. A factor is defined in federal regulations as "an organization, that is, a collection agency or service bureau which advances money to a provider for his accounts receivable which have been assigned or sold, or otherwise transferred to this organization for an added fee or a deduction of the accounts receivable." Power of attorney arrangements, under which a check is payable to the provider but can be cashed by a factor, are prohibited. However, payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order.



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Factor does not include a business representative, such as a billing agent or an accounting firm, which renders statements and receives payments in the name of the individual provider as long as the business representative's compensation for this service is:

- § Reasonably related to the cost of processing the claim;
- § Not related, in any way, to the dollar amount to be billed or collected; and
- § Not dependent upon the actual collection of payment.

This policy is not applicable to State-owned and -operated facilities.



SECTION 13 – RECORD KEEPING

13.1 RECORD RETENTION

Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries. Necessary records include fiscal and clinical records as discussed below. Appointment books and any logs are also considered a necessary record if the provider renders a service that is time-specific according to the procedure code billed. Examples of services that are time-specific are psychological testing (per hour), medical psychotherapy (20-30 minutes), and vision orthoptic treatment (30 minutes). The records are to be retained for a period of not less than six years from the DOS, regardless of change in ownership or termination of participation in Medicaid for any reason. This requirement is also extended to any subcontracted provider with which the provider has a business relationship.

13.2 PROVIDER'S ORDERS

Providers rendering or arranging services upon the written order of another provider (e.g., physician) must maintain that order for a period of six years.

13.3 BENEFICIARY IDENTIFICATION INFORMATION

Providers must retain the following beneficiary identification information in their records:

- § Name
- § Medicaid ID number
- § Medical record number
- § Address, including zip code
- § Birth date
- § Telephone number, if available
- § Any private health insurance information for the beneficiary, if available

13.4 AVAILABILITY OF RECORDS

Providers are required to permit MDCH personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the beneficiary as it is considered part of the treatment, payment and operations processes that do not require authorization under the HIPAA Privacy rule. Health plans contracting with the MDCH must be permitted access to all information relating to services reimbursed by the health plan.

Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying any record that must be maintained. (Failure to make requested copies available may result in the provider's suspension from Medicaid.) Records (exclusive of billings or charges) may only be released to other individuals if they have a release signed by the beneficiary authorizing access to his records.



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If the beneficiary or his representative requests charges, payments, or copies of claims billed to or paid by Medicaid, the beneficiary's request (including Medicaid ID number) should be directed to the MDCH Third Party Liability (TPL) Section. (Refer to the Directory Appendix for contact information.)

13.5 CONFIDENTIALITY

MDCH complies with HIPAA Privacy requirements and recognizes the concern for the confidential relationship between the provider and the beneficiary and protects this relationship using records and information only for purposes directly related to the administration of Medicaid.

All records are of a confidential nature and should not be released, other than to a beneficiary or his representative, unless the provider has a signed release from the beneficiary. Providers are bound to all HIPAA privacy and security requirements as federally mandated.

If the provider receives a court order or a subpoena for medical bills, the bills should be released. At the same time, copies of the court order or subpoena, released bills, and any additional information should be sent to the MDCH TPL Section. (Refer to the Directory Appendix for contact information.)

If there is a reason to suspect a duplicate payment has been or will be made, but the payment is not assigned, the provider should contact the TPL Section. TPL will make the necessary arrangements to collect the duplicate payment from the third-party source.

If the provider questions the appropriateness of releasing beneficiary records, he is encouraged to seek legal counsel before doing so.

13.6 FISCAL RECORDS

The following fiscal records must be maintained:

- § Copies of Remittance Advices (RA);
- § PA requests and approvals for services and supplies (including managed care authorizations);
- § Verification of medical necessity and the provider's usual and customary charge for the noncovered service;
- § Record of third-party payments; and
- § Copies of purchase invoices for items offered or supplied to the beneficiary.

13.7 CLINICAL RECORDS

The following table contains general guidelines for clinical documentation that must be maintained by all providers except nursing facilities. Clinical records other than those listed may also be needed to clearly document all information pertinent to services that are rendered to beneficiaries. All providers must refer to their specific coverage policy in this manual for additional documentation requirements. The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for services provided must be signed and dated by the rendering health care professional.



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For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin and end time of the particular service. For example, some Physical Medicine procedure codes specify per 15 minutes. If the procedure started at 3:00 p.m. and ended at 3:15 p.m., the begin time and end time must be recorded in the medical record.

The medical record must indicate the specific findings or results of diagnostic or therapeutic procedures. If an abbreviation, symbol, or other mark is used, it must be standard, widely accepted health care terminology. Symbols, marks, etc., unique to that provider must not be used.

Examples:

- § When a test is performed, at a minimum, the test value for that beneficiary for that test must be noted. Additionally, the normal range of values for the testing methodology should be annotated in the record.
- § When an x-ray is taken, the results or findings must be indicated. For example, a chest x-ray may indicate "no pulmonary edema present" or "no consolidation."
- § When a physical examination is performed, pertinent results or readings must appear.
- § If blood pressure is taken, the actual reading must appear.
- § If heart, lungs, eyes, etc., are checked, the results or findings must be detailed.
- § Medical/surgical procedures performed must be sufficiently documented to allow another professional to reconstruct what transpired (e.g., "I-D" is not sufficient documentation).
- § When a complete physical exam is rendered, the level of service must be fully documented.
- § If private duty nursing is provided, the care provided during each hour must be fully detailed.

Hospitals must retain any clinical information required to comply with 42 CFR 482.24. A nursing facility must retain any clinical information required to comply with 42 CFR 483.75(n) and the plan of care must comply with 42 CFR 483.20(d). These regulations are available from MDCH or Centers for Medicare and Medicaid Services (CMS). (Hospitals and nursing facilities should refer to the Reimbursement Appendix of their chapters in this manual for additional record keeping requirements.)



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Clinical Documentation Requirements

	Ambulance	CMHSP	Dentist	Family Planning	Hearing Aid Dealer	Hearing/Speech Center	Home Health	Hospice	Hospital	Lab	Medical Supplier	MI Choice	MSS/ISS	Pharmacy	Practitioner *	Private Duty Nursing Agency/RN & LPN	School Based Services	Vision
Date of Each Visit	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Begin Time & End Time if Service is Time-Specific According to Procedure / Revenue Code Billed	*	*	*			*	*	*	*	*		*			*	*	*	
Presenting Symptom, Condition	*	*	*	*	*	*	*	*	*			*	*		*	*	*	
Diagnosis	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Patient Histories, Plans of Care, Progress Notes, Consultation Reports	*	*	*	*		*	*	*	*		*	*	*		*	*	*	
Result of Exams		*	*	*		*		*	*						*		*	
Records of Medications, Drugs, Assistive Devices or Appliances, Therapies, Tests, and Treatments that are Prescribed, Ordered, or Rendered	*	*	*	*	*	*	*	*	*	*	*	*		*	*	*	*	
Physical Assessments and/or Nursing activities that pertain to care provided & support the services rendered and billed	*	*	*	*			*	*	*			*	*		*	*	*	
Orders for Tests & Test Results		*	*	*	*	*	*	*	*	*		*		*	*	*	*	
Pictorial Records or Graphs & Written Interpretations of Tests	*	*	*	*		*			*	*					*		*	
Identification of Specimen, Type & Source				*			*		*	*		*			*	*		
Test Methodology		*	*	*					*	*					*			*



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	Ambulance	CMHSP	Dentist	Family Planning	Hearing Aid Dealer	Hearing/Speech Center	Home Health	Hospice	Hospital	Lab	Medical Supplier	MI Choice	MSS/ISS	Pharmacy	Practitioner *	Private Duty Nursing Agency/RN & LPN	School Based Services	Vision
Name, Strength, Dosage, Quantity & Route of Drug, and Time Administered	x	x	x	x			x	x	x			x		x	x	x	x	
Ambulance Requestor's Name, Origination/ Terminating Location, Level & Type of Service	x								x						x		x	
Prescribing/Referring Physician		x	x	x		x	x	x	x	x	x	x	x	x	x	x	x	x
Transportation Information other than Ambulance		x							x				x				x	

* Includes MD, DO, DPM, DC, OD, Certified Nurse Midwife, Certified Nurse Anesthetist, Nurse Practitioner, Physical Therapist, Oral Surgeon, Medical Clinics (e.g., FQHCs, Public Health Clinics).



SECTION 14 – POST-PAYMENT REVIEW AND FRAUD/ABUSE

All Medicaid-reimbursed services are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post-payment reviews of paid claims may be conducted to assure that the services, as well as the rendering provider and setting, were appropriate, necessary, and comply with Medicaid policy. Post-payment review also verifies that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.), and that third party resources were utilized to the fullest extent available.

14.1 MDCH PROGRAM INVESTIGATION SECTION

The Program Investigation Section, as a federal mandate (42 CFR 455.14), is responsible for investigating all suspected Medicaid provider (FFS or managed care) fraud and/or abuse. To report suspected fraudulent activities to MDCH, contact the Program Investigation Section. (Refer to the Directory Appendix for contact information.) Suspected fraud and/or abuse is referred by the Program Investigation Section to the Michigan Department of the Attorney General, Medicaid Fraud Control Unit.

14.2 STATE LAW

The Michigan Department of Attorney General uses the following State laws for investigating provider fraud and abuse:

- § Medicaid False Claim Act (MCLA 400.601 et. seq.) An individual, whether a provider, an employee, or an accomplice, convicted of such an activity is subject to a fine of up to \$50,000 and a prison sentence of four to ten years for each count, as well as full restitution to Medicaid of all funds fraudulently obtained. The provider may be suspended from participating in Medicaid for a period of time and, in some instances, his license to practice his profession may be suspended or revoked.

Examples of Medicaid fraud are:

- Ø Billing for Services Not Rendered: A provider bills Medicaid for a treatment or procedure that was not actually performed (e.g., laboratory tests or x-rays that were not taken, full dentures were prior authorized and billed for when a partial denture was actually supplied).
- Ø Billing Without Reporting Other Resources: A provider bills Medicaid the full charge for a service without reporting the amount billed and received from another source (e.g., a private insurance company) or charging the patient for the service or a co-pay for a covered benefit.
- Ø Billing for a Brand Name Drug Not Dispensed: A pharmacy bills Medicaid for a brand name drug when a generic substitute (at a lower cost) was actually dispensed to the beneficiary.
- Ø Billing for Unnecessary Services: A provider misrepresents the diagnosis and symptoms on a beneficiary's record in order to provide and bill for unnecessary tests and procedures.



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- Ø Billing a DOS Other Than the Actual Date the Service was Rendered: A provider indicates a DOS other than the actual DOS that was during a time of beneficiary ineligibility or service noncoverage.
- Ø Receiving Kickbacks: An ancillary provider (e.g., physical therapist, laboratory, pharmacy) may agree to pay a physician, nursing facility, or hospital administrator or owner a portion of his Medicaid reimbursement for services rendered to the physician's patient or a beneficiary residing in the facility. Payments to a physician or facility administrator or owner may be a cash payment, a vacation trip, a leased vehicle, inflated rental for space, etc. Often a kickback arrangement results in unnecessary tests or services being provided to the beneficiary in order to generate additional reimbursement.
- Ø Fraudulent Cost Reports: A nursing facility or hospital including nonallowable costs or false information (e.g., understate patient census days) or including nonpatient care expenses (e.g., landscaping, interior design, or remodeling at the owner's or administrator's personal residence) in its cost report to justify a higher per diem or reimbursement rate from Medicaid.
- § Social Welfare Act (MCLA 400.111d): A conviction may result in a denial, suspension, or termination of the provider's license or similar action from Medicaid.
- § Public Health Code (MCLA 333.16226): A conviction may result in a fine or probation from Medicaid or the denial, suspension, or revocation of a provider's license.

MDCH encourages provider assistance in reducing and reporting provider fraud and abuse in Medicaid and violation of HIPAA Privacy regulations. Any provider or employee suspecting that a fraudulent activity is occurring should contact the Michigan Department of Attorney General. (Refer to the Directory Appendix for contact information.)

14.3 FEDERAL LAW

The Office of Inspector General of the United States Department of Health and Human Services (HHS) investigates provider fraud, abuse and violation of HIPAA Privacy and Security regulations under federal laws.

The following federal laws are primarily used:

- § Social Security Act (Section 1909). A conviction resulting in a penalty of up to 5 years imprisonment and/or a \$10,000 fine.
- § Civil Monetary Penalties Law of 1981 (Section 1128A of the Social Security Act). A conviction may result in a civil monetary penalty of not more than \$2,000 for each item or service, and an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the federal or state agency because of the fraudulent claim.

To report fraudulent activities to the federal investigators, contact the Office of Inspector General. Complaints regarding Michigan health facilities may be reported to the Michigan Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)



14.4 PATIENT ABUSE

Under federal law, the Department of Attorney General, Health Care Fraud Division (Medicaid Fraud Control Unit) is mandated to investigate and prosecute instances of patient abuse occurring in any Michigan facility receiving Medicaid funds.

Examples of patient abuse are:

- § Physical abuse, involving assaulting, striking, or sexually abusing a patient.
- § Threat or perceived threat of physical or sexual abuse.
- § Neglect resulting from inadequate medical or custodial care or other situations that create health risks to the patient.
- § Financial abuse, including misappropriation of patient's personal funds, co-mingling of patient and facility funds.
- § Use of patient funds to pay for facility operations, or theft of patient's property.

The above examples are not all inclusive.

Complaints involving suspected abuse of patients within any Michigan facility receiving Medicaid funds should be reported to the Michigan Department of Attorney General's 24-hour toll-free hotline. Complaints may also be mailed to the Attorney General's Medicaid Fraud Unit. (Refer to the Directory Appendix for contact information.)

Pursuant to Section 111b of the Social Welfare Act of 1939 (PA 280, as amended, MCLA 400.111b[7]), a provider is required to make available, to authorized agents of the Department of Attorney General, any record required that must be maintained as a condition of participation in Medicaid.

The Michigan Department of Attorney General also is empowered to investigate and prosecute any complaint involving patient abuse by a provider that receives Medicaid funds. It does not matter whether or not the abused patient is receiving Medicaid benefits. (Patient abuse is defined as harm or threat of harm to a patient's health or welfare by a person responsible for the patient's health or welfare that occurs through nonaccidental physical or mental injury, sexual abuse, or maltreatment.)

14.5 BENEFICIARY FRAUD/ABUSE

A provider can contact the local DHS in the beneficiary's county of residence to report beneficiary fraud, or contact the Office of Inspector General's Recipient Fraud Unit Hotline. (Refer to the Directory Appendix for contact information.)

The provider can also report beneficiary over-utilization of services by contacting the local DHS worker or the Beneficiary Monitoring Program. (Refer to the Directory Appendix for contact information.)



SECTION 15 - PROVIDER APPEAL PROCESS

Any provider participating in, or applicant wishing to participate in, Medicaid has the right to appeal any adverse action taken by MDCH unless the adverse action resulted from an action that MDCH had no control over (e.g., Medicare termination, license revocation). The method of appeal depends upon the provider type. Most providers are informed of the steps to be taken to appeal the action via the notice of adverse action. (Hospital providers may appeal at the time of adverse action, prior to the notice.) Institutional providers should refer to their respective chapters of this manual for the appropriate steps and time frames for appeal.

Any questions regarding this appeal process should be directed to MDCH Administrative Tribunal and Appeals Division. (Refer to the Directory Appendix for contact information.)



SECTION 16 - REVIEW OF PROPOSED CHANGES

The following guidelines for the development of policies, procedures, forms, and instructions apply to the Medicaid, Children's Special Health Care Services, Adult Benefits Waiver, and other health insurance programs administered by MDCH.

MDCH consults with affected providers and other interested parties on those proposed changes in Medicaid policies, procedures, forms, and instructions which are determined significant enough to be communicated to providers by means of a provider bulletin. This consultation process involves a notification of the proposed change and the reasons for the change. MDCH includes the distribution of draft policy to those parties who have expressed interest in reviewing and commenting on the changes.

Affected provider means any enrolled provider or provider association/organization that is impacted by the proposal changes. Any affected provider or other interested party who would like an opportunity to comment on any proposed changes in his area of interest (e.g., podiatry, hospital, vision) may do so.

Visit the MDCH website to review draft policies or to request draft policies be sent to you for comment. You may also contact MDCH directly to request to participate in the policy promulgation process. (Refer to the Directory Appendix for contact information.)

Your request to receive draft policies must include:

- § Provider's/Individual's name;
- § Telephone number;
- § Mailing address (and E-mail address, if requesting electronic distribution);
- § Involvement with Medicaid (e.g., Medicaid provider, drug manufacturer, interested party);
- § Association/organization represented (if applicable); and
- § Specific area of interest to review and comment on (e.g., physician, ambulance, hospital, Maternal Support Services (MSS)/Infant Support Services (ISS), dental, nursing facilities).

Copies of draft bulletins are sent to interested parties via e-mail or US mail, and are posted on the MDCH website for a minimum of 30 days. Anyone wishing to comment on proposed changes may submit comments electronically, by fax or by US mail within the comment period.

Comments received are considered and suggestions may be incorporated in the final policy if determined appropriate. Upon completion of the consultation process, a provider bulletin serves as final notice of the change. A summary of the comments made, MDCH's response, and a copy of the final bulletin are sent to those who submitted comments. Proposed changes may have to be implemented before comments are considered if specific action is ordered by governmental entities having authority over MDCH with time frames that do not allow full compliance with the consultation process. In these cases, comments are requested from affected providers and are considered for incorporation after the implementation of the change.



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MDCH consults with the Medical Care Advisory Council (composed of consumers, providers, and government officials) in the review of proposed policies and procedures prior to implementation. Numerous provider associations and organizations are also involved in the review process. A provider who feels that his association or the Medical Care Advisory Council adequately represents him may not wish to be included on the provider consultation list.



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SECTION 1 – DETERMINATION OF ELIGIBILITY

This chapter applies to all providers.

1.1 LOCAL DEPARTMENT OF HUMAN SERVICES OFFICE DETERMINATION [CHANGE MADE 7/1/05]

Eligibility for Medicaid and most other health programs is determined at the local Department of Human Services (DHS) office. The DHS worker reviews the beneficiary's financial and nonfinancial (e.g., disability, age) factors and determines the types of assistance for which the beneficiary is eligible. Once eligibility is established, the data is entered on the electronic Eligibility Verification System (EVS) and a **mihealth** card is issued.

MDCH determines eligibility for Children's Special Health Care Services (CSHCS).

Some Medicaid beneficiaries are in a **deductible (changed 7/1/05)** situation. This means the beneficiary has met all Medicaid eligibility criteria except he has excess income. (Refer to the **Medicaid Deductible (changed 7/1/05)** Beneficiaries Section of this chapter for additional information.)

Migrant agricultural workers may also be eligible for health care benefits. However, due to the transient nature of the migrant population, they might not receive their **mihealth** card. The provider must call EVS to verify eligibility when a beneficiary indicates he is a health care program beneficiary and does not have a **mihealth** card. (Refer to the Verifying Beneficiary Eligibility Section of this chapter for additional information.)

1.2 ELIGIBILITY BEGIN DATE [CHANGE MADE 7/1/05]

Coverage is usually effective the first day of the month that the beneficiary becomes eligible.

- § Not all beneficiaries, however, are eligible beginning the first day of the month. Coverage may become effective the actual day the beneficiary becomes eligible.
- § In some instances, the beneficiary's eligibility may be retroactive up to three months prior to the month of application. This may occur if, during the retroactive period:
 - Ø All eligibility requirements for the specific health care program were met; and
 - Ø Medical services were rendered.

The provider may submit claims to MDCH for payment of any covered services rendered during the beneficiary's eligibility period. If the beneficiary has previously paid for services and the provider has billed MDCH for the same services, the provider must refund to the beneficiary the portion of payment the beneficiary is responsible for, regardless of the amount MDCH pays. (Refer to the **Medicaid Deductible (changed 7/1/05)** Beneficiaries Section of this chapter for additional information.)



1.3 REDETERMINATIONS

Beneficiary eligibility is redetermined annually but may occur more often, as case circumstances dictate. Beneficiaries are notified of the need to have their cases redetermined and the process to be followed to accomplish this.

1.4 BENEFICIARY APPEALS

Beneficiaries may appeal their eligibility determination/redetermination by contacting their DHS worker at the local DHS office.

1.5 CORRECTIVE ACTION

Beneficiaries that have been denied Medicaid eligibility and have filed a hearing request may be entitled to a reimbursement if they paid for Medicaid covered services during a corrective action period. The corrective action period begins on the date the hearing request is received by the Department of Human Services (DHS) and ends on the date that eligibility is established. The services received must have been provided during the established eligibility period, including any months of established retroactive eligibility.

The provider has the option to reimburse the beneficiary in full and bill Medicaid for services rendered. MDCH encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider chooses not to reimburse the beneficiary, the beneficiary can request a direct reimbursement from the State.

In order to be eligible for a direct reimbursement from the State, the beneficiary, or someone legally responsible for the beneficiary's bills, must have paid for a Medicaid covered service during the corrective action period. The beneficiary cannot receive reimbursement for any required copays, patient pay amounts, amounts used to meet a Medicaid deductible, or care or services paid for through private insurance, Medicare, or any other form of government-sponsored or private health care coverage.

To request a refund of medical expenses, the beneficiary must provide a copy of all bills for medical services received on or after February 2, 2004, for which the beneficiary, or someone legally responsible for the beneficiary's bills, paid during the corrective action period to MDCH.

Bills must include or contain:

- § Beneficiary name;
- § Date the care or service was received;
- § Amount charged for the care or service;
- § Amount paid by the beneficiary or legally responsible party;
- § Date the bill was paid;
- § Procedure code(s) for the care or service;
- § Description of each care or service, e.g., office visit, physical therapy, etc. Drug name, quantity dispensed, and the name of the prescribing physician must be included for prescriptions; and
- § Proof of any payment made by a third party, such as an insurance company.



SECTION 2 – MIHEALTH CARD

The provider must verify beneficiary eligibility on the EVS prior to rendering services for:

- § Medicaid
- § CSHCS
- § Transitional Medical Assistance-Plus (TMA-Plus)
- § Maternity Outpatient Medical Services (MOMS) programs
- § Adult Benefits Waiver (ABW)

(Refer to the Verifying Beneficiary Eligibility Section of this chapter for additional information.)

The **mihealth** card is a plastic, magnetic strip identification card issued once to each beneficiary. The front of the card contains the beneficiary's name and beneficiary ID number. When a family is determined eligible for a health program, a **mihealth** card is issued to each eligible person in the household. All cards for a household are mailed to the head of the household. The **mihealth** card does not contain eligibility information and does not guarantee eligibility until verified through EVS that the person is covered.

The provider can use the **mihealth** card to access a beneficiary's eligibility information on the EVS by entering the Medicaid ID number or swiping the card using a magnetic strip reader. Contact the MDCH EVS vendor who can provide more information on magnetic strip readers and software. (Refer to the Directory Appendix for contact information.)

The eight-digit beneficiary identification (ID) number obtained from the EVS must be used when billing Medicaid.

The provider should request the beneficiary present a **mihealth** card to access a beneficiary's information on the EVS to verify health program eligibility before rendering any service. If the beneficiary does not have a **mihealth** card, the provider can also access the beneficiary's eligibility information on the EVS with the following additional search methods:

- § Beneficiary ID number.
- § Beneficiary social security number (SSN) and date of birth (DOB).
- § Beneficiary name and SSN (or DOB).

If the beneficiary has lost his **mihealth** card, a replacement card may be issued by contacting the Beneficiary Helpline. (Refer to Directory Appendix for contact information.) The provider is encouraged to verify a beneficiary's identity by requesting additional identification (e.g., driver's license, State Police ID, SS Card).

If the provider suspects fraud, the case should be reported to the Office of Inspector General. (Refer to the Directory Appendix for contact information.)

Suspected cases of beneficiary program abuse should be sent to the MDCH Program Investigation Section. (Refer to the Directory Appendix for contact information.)



Occasionally, the provider may see a Statement of Medical Services Paid (MSA-110-EOB). This statement is for the beneficiary's information only and indicates services received and paid on his behalf by MDCH.

2.1 SCOPE/COVERAGE CODES [CHANGES MADE 7/1/05]

The provider must always note the beneficiary's scope/coverage code, which indicates the extent of Medicaid coverage. The scope/coverage code is two characters. The first character (numeric) indicates the scope of eligibility. This code is used for administrative purposes only.

Scope Code	Program	Qualifying Information
1	Medicaid	When used in conjunction with Coverage Codes E, F, P, Q, T, U, or V (modified 7/1/05)
2	Medicaid	When used in conjunction with Coverage Codes B, C, E, F, J, H, T, V, or 0 (zero) (modified 7/1/05)
3	Adult Benefit Waiver (ABW)	When used in conjunction with Coverage Codes G, M, or R
4	Refugees and Repatriates	When used in conjunction with Coverage Code F

The second character (alpha) indicates the coverage available for this beneficiary. It is this part of the scope/coverage code that the provider should be aware of prior to rendering the service.

Coverage Code	Qualifying Information
0 (zero)	No Medicaid eligibility/coverage (Refer to Medicaid Deductible (changed 7/1/05) Beneficiaries Section of this chapter for more information)
B	Qualified Medicare Beneficiary (QMB) (pays Medicare Parts A & B premiums, coinsurances, and deductibles) (added 7/1/05)
C	Specified Low Income Medicare Beneficiary (SLMB) (pays Medicare Part B premium) (added 7/1/05)
D	Freedom to Work Beneficiary (full Medicaid coverage) (added 7/1/05)
E	Emergency or urgent Medicaid coverage only
F	Full Medicaid coverage



Coverage Code	Qualifying Information
G	Adult Benefits Waiver (ABW) (full ABW coverage) (added 7/1/05)
H	Additional Low Income Medicare Beneficiary (ALMB) (pays Medicare Part B premium) (added 7/1/05)
J	Additional Low Income Medicare Beneficiary (ALMB) (pays part of Medicare Part B premium) (added 7/1/05)
K	Freedom to Work Beneficiary (full Medicaid coverage) (added 7/1/05)
M	PLUS CARE (Wayne County) (full PLUS CARE coverage) (added 7/1/05)
P	Transitional Medical Assistance-Plus (TMA-Plus) (full Medicaid coverage)
Q	Medicare Qualified Disabled Working Individual (full Medicaid coverage) (added 7/1/05)
R	Resident County Hospitalization only (administered by the local DHS office)
T	Healthy Kids (full Medicaid coverage) (added 7/1/05)
U	Transitional Medical Assistance-Plus (TMA-Plus) (emergency services only)
V	Healthy Kids (emergency services only) (added 7/1/05)
Y	Family Planning Waiver (family planning services only) (added 7/1/05)

2.2 PATIENT PAY INFORMATION

Patient pay is the beneficiary's financial liability. It is shown in whole dollars only (e.g., 00050 is \$50.00, not 50 cents). This amount applies to inpatient hospitals, nursing facilities (including ICF/MR facilities), and hospice while in a nursing facility. (Refer to Patient Pay Amount Section of this chapter for more information.)



2.3 LEVEL OF CARE CODES

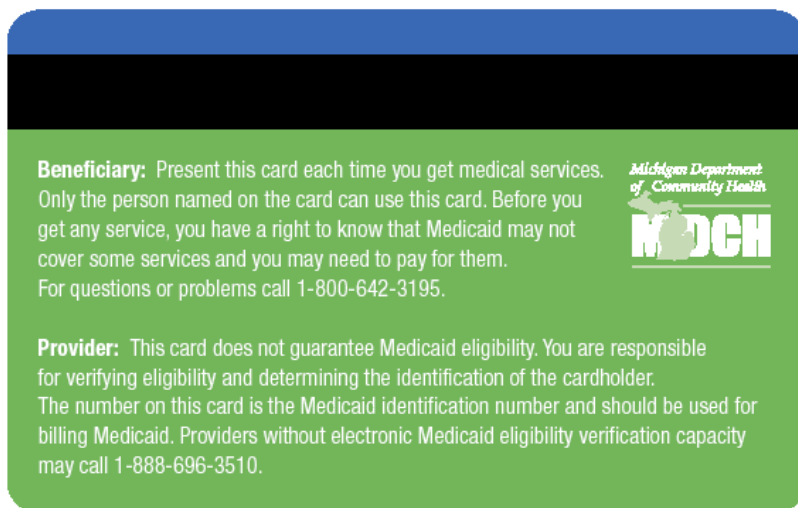
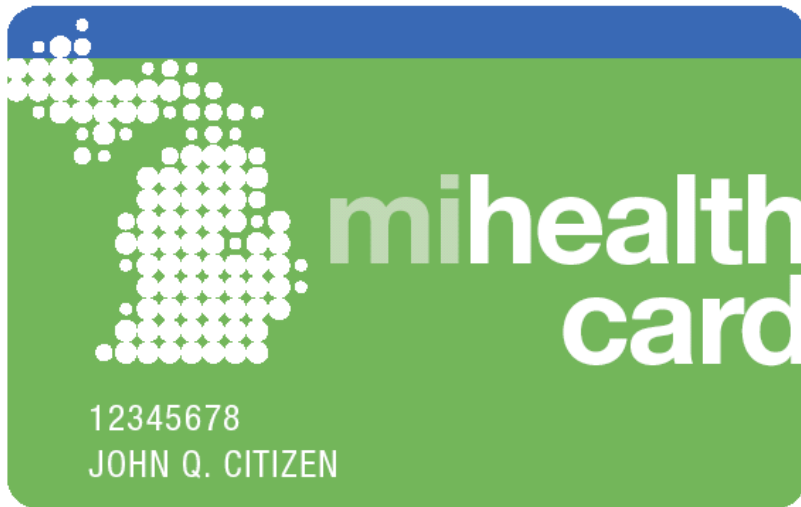
The EVS indicates one of the following codes:

Level of Care Code	Description
Blank	No LOC code. Beneficiary is considered to be fee-for-service (FFS).
02	Beneficiary of nursing facility services (e.g., nursing home, medical care facility, hospital long-term care unit).
11	Beneficiary in Adult Benefit Waiver I Program – County Plan.
07	Beneficiary is enrolled in a Medicaid Health Plan (MHP) or Program of All-Inclusive Care for the Elderly (PACE). (Refer to the Medicaid Health Plans Section of this chapter for more information.)
08	Developmentally disabled beneficiary in an intermediate care facility for the mentally retarded (ICF/MR and Mt. Pleasant Regional Center only).
10	The beneficiary has a patient pay amount for inpatient hospital acute care.
13	Beneficiary is on the Beneficiary Monitoring Program Pharmaceutical Lock-In. (Refer to the Beneficiary Monitoring Program Section of this chapter for more information.)
14	Beneficiary is on the Beneficiary Monitoring Program Restricted Primary Provider Control. (Refer to the Beneficiary Monitoring Program Section of this chapter for more information.)
16	Beneficiary is in a hospice program.
22	Beneficiary is enrolled in MI Choice, the Home and Community-Based Services Waiver for the Elderly and Disabled.
32	Beneficiary is involuntarily residing in a detention facility. Medicaid coverage limited to inpatient hospital related services only.
55	The need for long term care has been disapproved by the agency responsible for certifying the need for nursing care.
56	Services provided/billed by a long term care facility or waiver are not covered. Services provided by the facility may be billed to the beneficiary. Services provided/billed by other providers are covered if Medicaid guidelines are met.



Level of Care Code	Description
88	Administrative purposes. Medical exception to managed care enrollment. The beneficiary should be treated as if the LOC code was blank.

2.4 MIHEALTH CARD SAMPLE





2.5 SPECIAL PROGRAMS – BENEFICIARY IDENTIFICATION [CHANGE MADE 7/1/05]

Program/Eligibility Type	Level of Care	Scope/Coverage	Message
Health Plan	07	1F, 2F, 4F	HMO ENROLLEE, Health Plan Name and Phone Number
Wayne County PLUS CARE – Also need County Code 82 and Coverage Code G or H to identify a PLUS CARE beneficiary	11	3M	PLUS CARE contractor's name and telephone number - ID Card is issued by Plus Care
Adult Benefits Waiver (ABW) – County Plan	11	3G	
ABW – Emergency Services Only	Blank	3E	
Beneficiary Monitoring Program – Pharmaceutical Control	13	1F, 2F, or 4F	Pharmaceutical Lock-in
Beneficiary Monitoring Program – Restricted Primary Provider Control	14	1F, 2F, or 4F	Restricted Provider Control, Provider Name and ID number
Qualified Medicare Beneficiary (QMB) – Medicaid pays Medicare Part B premiums, coinsurance, and deductibles	Blank	2B	Medicare Coinsurance/Deductible Only
Additional Low-Income Medicare Beneficiary (ALMB)			
Type 1 or Q1 – Medicaid pays the entire Medicare Part B premium	Blank	2H	No mihealth card is issued. No Medicaid coverage exists.
Type 2 or Q2 – Medicaid pays a portion of the annual Medicare Part B premium to the beneficiary	Blank	2J	No mihealth card is issued. No Medicaid coverage exists.
Qualified Disabled Working Individual (QDWI) - Medicaid pays the Medicare Part A premium.	--	1Q	No mihealth card is issued. No Medicaid coverage exists.



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Program/Eligibility Type	Level of Care	Scope/Coverage	Message
Specified Low Income Medicare Beneficiary (SLMB) – Medicaid pays the Medicare Part B premium	--	2C	No mihealth card is issued. No Medicaid coverage exists.
Limited Medicaid Coverage (Medicaid only covers urgent/emergent services)	Blank	1E or 2E	Urgent/Emergent Services Only
Medicaid Deductible (changed 7/1/05)– Scope/Coverage code 2F or 2E is added when the beneficiary provides documentation of meeting the deductible amount to the DHS worker	Blank	20 (zero)	No Medicaid coverage exists until beneficiary incurs sufficient medical expenses to meet the deductible (changed 7/1/05) amount.
Medicaid Deductible (changed 7/1/05) and QMB – Medicaid pays Medicare Part B premiums, coinsurance, and deductibles for the entire month	Blank	2B or 2C	No Medicaid coverage for Medicaid-covered services exists until beneficiary incurs sufficient medical expenses to meet the deductible (changed 7/1/05) amount.



SECTION 3 – VERIFYING BENEFICIARY ELIGIBILITY

The **mihealth** card does not contain eligibility information and does not guarantee eligibility. The provider can use the **mihealth** card to access a beneficiary's eligibility information on the EVS.

3.1 ELIGIBILITY VERIFICATION SYSTEM [CHANGE MADE 10/1/05]

Beneficiary information obtained from EVS is confidential under federal guidelines. EVS information must be used only for verifying beneficiary eligibility. If the beneficiary is eligible, the following information is available from the EVS:

- § Beneficiary name, beneficiary ID number, gender, DOB.
- § Eligibility information for the date of service (DOS) for:
 - Ø Medicaid
 - Ø ABW
 - Ø CSHCS
 - Ø TMA-Plus
 - Ø MOMS
 - Ø **MiChild (added 10/1/05)**
- § Program code, scope/coverage code, and patient-pay amount. (MOMS, **CSHCS**, and **MiChild (added 10/1/05)** program beneficiaries are identified separately and do not use scope/coverage codes.)
- § Current county of residence, DHS case number, DHS worker load number, and **DHS local office phone number. (added 10/1/05)**
- § Verification of whether or not the provider is authorized by the CSHCS program to render services to this beneficiary on a particular DOS or period of time.
- § **Dental program information (added 10/1/05)**
- § Third-party liability (TPL), other insurance information, carrier ID or other insurance code, policy number, contract number, and services code (if applicable) and employer name and policyholder name.
- § Level of care (LOC) information, such as health plan enrollment or Beneficiary Monitoring Program.

No additional information is provided by the EVS.

3.2 ACCESSING EVS [CHANGE MADE 10/1/05]

Providers may enter the EVS in one of two ways:

- § By using a touch-tone telephone (or rotary telephone with a tone dialer), the provider receives information through a voice response system. This method is free to the provider. (Refer to the Directory Appendix for contact information.)



- § Other methods for verifying eligibility are available that feature batch capabilities, quicker response time and offer printed verification of eligibility. These methods may involve a charge to the provider. For more information, contact the EVS vendors. (Refer to the Directory Appendix for contact information.)

The **mihealth** card uses magnetic swipe technology that allows providers to access beneficiary eligibility information quicker and easier with the use of a magnetic strip reader. For more information on magnetic strip readers and software, contact the EVS vendor. (Refer to the Directory Appendix for contact information.)

3.3 ELIGIBILITY VERIFICATION FOR DATES OF SERVICE OVER 12 MONTHS OLD

MDCH follows CMS guidelines regarding release of eligibility information. Requests for information over 12 months from the date of request are only provided to hospitals. To obtain this information, hospitals should contact the MDCH EVS vendor during normal business hours. (Refer to the Directory Appendix for contact information.) There is a transaction fee to the requester.



SECTION 4 –MEDICAID DEDUCTIBLE BENEFICIARIES [RENAMED & CHANGES MADE 7/1/05]

4.1 ELIGIBILITY

There are cases when beneficiaries have the medical need for Medicaid coverage but they have excess income. These beneficiaries are known as **Medicaid deductible (changed 7/1/05)** beneficiaries. Medicaid deductible means that the beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local DHS worker to qualify for Medicaid. Once his **deductible (changed 7/1/05)** amount has been met, he becomes eligible for Medicaid benefits (Scope/Coverage Code 2F or 2E). Providers must verify Medicaid coverage using the Scope/Coverage Code available from the EVS.

The process for a **Medicaid deductible (changed 7/1/05)** beneficiary to become Medicaid eligible is as follows:

- § The beneficiary presents proof of any medical expenses incurred (e.g., insurance premiums, bills for prescriptions and/or office visits) to the DHS worker. Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. If the exact charge is not immediately known, providers should estimate the charge on the incurred bill. This expedites the eligibility process.
- § The local DHS worker reviews the medical bills incurred and determines if the amount of beneficiary liability is met and the first date of Medicaid eligibility.
 - Ø It is fraud to provide beneficiaries with a notice of a bill incurred if no service has been rendered.
 - Ø Bills for services rendered prior to the effective date of Medicaid eligibility are the beneficiary's responsibility.
- § For the first date of eligibility, the DHS worker sends letters to those providers whose services are:
 - Ø Entirely the beneficiary's responsibility.
 - Ø Partly the beneficiary's responsibility and partly Medicaid's responsibility.
- § A letter is also sent to the beneficiary indicating which services are the beneficiary's responsibilities for that first date of Medicaid eligibility.
- § The beneficiary's Scope/Coverage Code is changed to 2F or 2E to indicate the Medicaid eligibility period. The provider must verify eligibility on EVS when the beneficiary becomes eligible. Once the **deductible (changed 7/1/05)** amount is met, eligibility is established through the end of the month.

Providers may bill Medicaid for any covered services rendered during that eligible period.

Before billing, providers should verify through the EVS that Scope/Coverage Code 2F or 2E has been entered into the system. This will assure that the claims will not be rejected for lack of eligibility.



4.2 RETROACTIVE ELIGIBILITY [CHANGES MADE 7/1/05]

Providers should be aware that, since bills have to be incurred before the deductible (changed 7/1/05) amount is met, there is always a period of retroactive eligibility. This may be several days or up to a period of three months from the current month. In this situation, the local DHS office may apply these old bills to the past three months or may prospectively apply them to the next several months, depending on the DOS and the date the bill was presented to the DHS worker.

It is the provider's option to bill Medicaid if the beneficiary has paid the provider for services rendered. MDCH encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider decides to bill Medicaid, he must return all money the beneficiary paid over and above the amount identified as the beneficiary's responsibility on the Medicaid deductible (changed 7/1/05) letter. If the beneficiary is accepted as a Medicaid beneficiary, he cannot be charged more than indicated on the letter from the local DHS office (plus applicable co-payment amounts).

4.3 BILLING INSTRUCTIONS [CHANGES MADE 7/1/05]

There may be services that are partly the beneficiary's liability and partly Medicaid's liability. If the provider chooses to bill Medicaid for this service, he should refer to the Billing & Reimbursement Chapters of this manual for instructions for submitting claims.

Beneficiaries are responsible for payment of expenses that were incurred to meet the deductible (changed 7/1/05) amount. Payment does not have to be made before Medicaid eligibility is approved.

(Refer to the Qualified Medicare Beneficiary Section of this chapter for information on Medicaid deductible (changed 7/1/05) beneficiaries and Scope/Coverage Code 2B.)



SECTION 5 - CONTRACTUAL CARE ARRANGEMENTS FOR LONG TERM CARE

A **life care contract** is created when an individual enters into an agreement with a continuing care retirement community to provide for all the individual's needs, including health care, for the rest of his life. The individual pays a one-time entrance fee and monthly payments thereafter. The continuing care retirement community assumes full financial responsibility if the individual is unable to make his monthly payments at a later date. An individual with a life care contract is not eligible for Medicaid.

A **continuing care contract** is created when an individual enters into an agreement with a continuing care retirement community to provide or pay for all, or some of, the individual's medical care for the rest of his life. The individual pays a one-time entrance fee and monthly payments thereafter. An individual with a continuing care contract may be eligible for some Medicaid services.



SECTION 6 – QUALIFIED MEDICARE BENEFICIARY

6.1 GENERAL INFORMATION

Federal regulations require that Medicaid purchase Medicare coverage for some beneficiaries and reimburse providers for the Medicare coinsurance and deductible amounts. If these beneficiaries are not also eligible for Medicaid, they have Scope/Coverage Code 2B, Qualified Medicare Beneficiary (QMB). Medicaid only reimburses providers for the Medicare coinsurance and deductible amounts up to the Medicaid maximum amount. Medicaid does not reimburse services not covered by Medicare.

6.2 MEDICAID DEDUCTIBLE BENEFICIARIES AND QMB [RENAMED & CHANGES MADE 7/1/05]

Beneficiaries may be a QMB and also a Medicaid deductible (changed 7/1/05) beneficiary. Until the deductible (changed 7/1/05) amount has been met, the EVS shows Scope/Coverage Code 2B. Once the deductible (changed 7/1/05) amount is met, the Scope/Coverage Code is changed to 2F (full Medicaid benefits) and EVS is updated. For this Medicaid eligibility period, Medicaid reimburses the provider for Medicaid-covered services, as well as the Medicare coinsurance and deductible amounts up to the Medicaid allowable.

If Medicare covers the service, the provider may bill Medicaid for the coinsurance and deductible amounts only. For any Medicare noncovered services, the beneficiary should obtain proof of the incurred medical expense to present to the DHS worker so the amount may be applied toward the beneficiary's Medicaid deductible (changed 7/1/05) amount.



SECTION 7 – NEWBORN CHILD ELIGIBILITY

A newborn is defined as a child aged 0 (birth) to 1 year old. Generally, Medicaid automatically covers a child born to a woman eligible for and receiving Medicaid at the time of the birth. The mother is required to notify the local DHS office of the birth of the newborn within ten days of the birth.

If the mother is enrolled in a Medicaid Health Plan (MHP) at the time of delivery, the newborn's services are also the responsibility of the health plan unless the child is placed in foster care or enrolled in CSHCS.

7.1 FACILITY ADMISSION NOTICE

In the few cases where this process may be delayed, any provider may notify the local DHS office of the newborn's birth by submitting a Facility Admission Notice form (MSA-2565-C). (Refer to the Forms Appendix for a sample.) The form is to be completed for the newborn and must include the following information:

- § Item 6 must state the name of the mother.
- § Item 20 must state "newborn."
- § A copy of the mother's EVS information should be attached to the form, or Item 22 must contain the County, District, Unit, Worker, case number data from EVS separated by slashes (e.g., 33/01/01/08/K3300772A).

The local DHS office enters the newborn's data on EVS and returns the MSA-2565-C to the provider with the necessary billing information.

Eligibility information must be obtained from EVS using the newborn ID number provided by MDCH. When an EVS query does not locate the newborn, inquiries should be directed to the MDCH Enrollment Services Section. (Refer to the Directory Appendix for contact information.) All inquiries must include the following information to assist MDCH in locating newborn ID numbers:

- § Newborn's name (last, first, middle initial).
- § Newborn's gender.
- § Newborn's DOB.
- § Mother's name (last, first, middle initial).
- § Mother's Medicaid ID number.
- § Requesting person's name and telephone number.

7.2 BILLING

When billing MDCH for medical services rendered to the newborn, providers must use the newborn's Medicaid ID number. The mother's number cannot be used except when the delivering physician performs the newborn's care and circumcision during the mother's inpatient stay. In that situation, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.



SECTION 8 – BENEFICIARY MONITORING PROGRAM

State and federal regulations require MDCH to conduct surveillance and utilization review of Medicaid benefits to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to Medicaid beneficiaries. The objectives of the Beneficiary Monitoring Program (BMP) are to reduce overuse and/or misuse of Medicaid services (including prescription medications), improve the quality of health care for Medicaid beneficiaries, and reduce costs to the Medicaid program. To accomplish these objectives, MDCH:

- § Identifies FFS beneficiaries who appear to be misusing and/or overusing Medicaid services.
- § Evaluates the Medicaid services to determine whether the services are appropriate to a FFS beneficiary's medical condition(s).
- § If it is determined that a Medicaid FFS beneficiary is overusing and/or abusing Medicaid services, the beneficiary may be subject to a utilization control (lock-in) mechanism. There are two types of utilization control mechanisms for BMP:
 - Ø Pharmaceutical Lock-In used for beneficiaries who are abusing and/or misusing drugs listed in the Drug Categories subsection below.
 - Ø Restricted Primary Provider Control used for beneficiaries who are misusing and/or abusing Medicaid services other than pharmaceuticals.
- § Monitors FFS beneficiaries in the control mechanism to determine whether control is effective and, if not effective, make appropriate changes.

A beneficiary who is subject to the BMP Pharmaceutical Control mechanism is identified by LOC code 13 with the message "Pharmaceutical Lock-in".

A beneficiary who is subject to the BMP Restricted Primary Provider Control mechanism is identified by LOC code 14 with the message "Restricted Provider Control".

8.1 ENROLLMENT CRITERIA

The following criteria are used to determine whether a beneficiary may be placed in the Pharmaceutical Lock-in or Restricted Primary Provider Control mechanism. The dosage level and frequency of prescriptions, as well as the diagnoses and number of different prescribers, are reviewed when evaluating each individual case.

8.1.A. DISENROLLMENT FROM A MEDICAID HEALTH PLAN

MDCH has disenrolled the Medicaid beneficiary from an MHP for one of the following:

- § Noncompliance with physician/drug treatment plan.
- § Noncompliance with MHP rules/regulations for pharmacy lock-in.
- § Suspected/Alleged fraud for altered prescriptions.
- § Suspected/Alleged fraud for stolen prescription pads.



8.1.B. CONVICTED OF FRAUD

The beneficiary has been convicted of fraud for one of the following:

- § Selling of products/pharmaceuticals obtained through Medicaid.
- § Altering prescriptions used to obtain medical products or pharmaceuticals.
- § Stealing prescription pads.

8.1.C. INAPPROPRIATE USE OF EMERGENCY ROOM SERVICES

- § More than three emergency room visits in one quarter.
- § Repeated emergency room visits with no follow-up with a primary care physician.
- § More than one outpatient hospital emergency room facility used in a quarter.

8.1.D. INAPPROPRIATE USE OF PHYSICIAN SERVICES

- § Utilized more than three different physicians in one quarter.
- § Utilized more than two different physicians to obtain duplicate services for the same health condition or prescriptions for the drug categories defined below.
- § Utilized multiple physicians for vague diagnosis (e.g., myalgia, myositis, sinusitis, lumbago, migraine) to obtain drugs from the drugs categories defined below.

8.1.E. INAPPROPRIATE USE OF PHARMACY SERVICES

- § Utilized more than three different pharmacies in one quarter.
- § Aberrant utilization patterns for drug categories noted below over a one-year period.
- § Obtained more than 11 prescriptions for drugs identified below in one quarter (including emergency prescriptions).

8.2 DRUG CATEGORIES

MDCH considers the following categories of drugs to be subject to abuse. Beneficiaries obtaining these products, and meeting the criteria above may be subject to enrollment in the BMP.

- § Narcotic Analgesics
- § Barbiturates
- § Sedative-Hypnotic, Non-Barbiturates
- § Central Nervous System Stimulants/Anti-Narcoleptics
- § Anti-Anxieties
- § Amphetamines
- § Skeletal Muscle Relaxants



8.3 PHARMACEUTICAL LOCK-IN CONTROL MECHANISM

Michigan's Pharmacy Benefits Manager maintains a real-time screen of all point of sale (POS) prescription drug claims for MDCH. Requests for prescriptions (including emergency prescriptions for the therapeutic drug categories listed above) are evaluated against other prescriptions filled for the beneficiary and paid by Medicaid in the last 34 days.

Beneficiaries are not allowed to fill or refill prescribed medications in the drug categories listed above until 95 percent of the medication quantity limits would have been consumed in compliance with the prescribed dose, amount, frequency and time intervals established by the MDCH.

No over-rides are allowed for beneficiaries enrolled in the BMP except when authorized by the MDCH Office of Medical Affairs (OMA).

8.4 RESTRICTED PRIMARY PROVIDER CONTROL MECHANISM

Beneficiaries are enrolled in the Restricted Primary Provider control mechanism if they are identified as abusing or misusing Medicaid services other than pharmaceuticals. It is the responsibility of the restricted beneficiary's primary care provider to supervise the case management and coordination of all prescribed drugs, specialty care and ancillary services. Reimbursement for any ambulatory service is not made unless the services rendered were provided, referred, prescribed, or ordered by the primary provider.

The primary care provider must complete the Beneficiary Monitoring Primary Provider Referral Notification/Request (MSA-1302) to authorize care by other physicians (MD, DO), medical clinics, and outpatient hospitals. (Refer to the Forms Appendix for a copy of the form and distribution instructions.)

- § The MSA-1302 does not authorize prescriptions ordered or written by the referred provider.
- § The MSA-1302 does authorize the referred medical provider to render the service. The MSA-1302 is valid for a 60-day period from the date of the first appointment with the referred provider.

A telephone referral is adequate authorization to render the service. However, the primary provider must immediately forward one copy of the MSA-1302 to the referred provider and one copy to the Beneficiary Monitoring Program.

Any authorization by the primary care provider of the restricted beneficiary does not replace any prior authorization (PA) required by MDCH (e.g., vision services, cosmetic surgery).

A monthly case management fee is paid to the Restricted Primary Provider for each beneficiary assigned.

The following services are exempt from the primary care physician beneficiary utilization control mechanism:

- § Emergency services
- § Dental services
- § Services rendered by a nursing facility (NF) provider
- § Services rendered in an inpatient hospital



8.5 REFERRAL SERVICES

If a provider receives a referral from a beneficiary's primary care provider and wishes to order any services that will be performed by another provider (e.g., laboratory tests, prescription drugs, physical therapy, outpatient services), the order for such services must be authorized or prescribed by the primary provider. Medicaid reimburses only for those services billed using the primary provider as the referring/prescribing physician.

The referred provider must:

- § Receive his copy of the MSA-1302 before billing Medicaid for the services;
- § Retain the form in the beneficiary's file as authorization for the service; and
- § Use the provider ID number identified in the MSA-1302 for billing.

8.6 MONITORING AND REVIEW

Beneficiaries are placed into the BMP for a minimum of 24 months. The utilization of medical services or drugs is routinely monitored and the effectiveness of the current control mechanism evaluated. When the beneficiary's utilization has been reduced to an appropriate level or there is a change in medical status, MDCH may determine that the BMP is no longer required.

8.7 APPEALS

Beneficiaries may appeal MDCH's action to place them in pharmaceutical lock-in and/or primary care provider utilization control.



SECTION 9 – MEDICAID HEALTH PLANS

MDCH contracts with health plans in the state. The Medicaid Health Plans (MHPs) are paid a monthly capitation rate to provide specific covered services to enrolled Medicaid beneficiaries. The MHP is responsible for providing, arranging, and reimbursing most medical services.

9.1 ENROLLMENT [CHANGES MADE 7/1/05]

Within the Medicaid population, there are groups that:

- § Must enroll in a MHP.
- § May voluntarily enroll in a MHP.
- § Are excluded from enrollment in a MHP.

Mandatory Enrollment	<ul style="list-style-type: none"> § Most people who are receiving full Medicaid benefits. § People receiving Medicaid who participate in the Children’s Home and Community Based Waiver (MIChoice) or the Habilitation/Supports Home and Community Based Waiver. § Supplemental Security Income (SSI) beneficiaries who do not receive Medicare.
Voluntary Enrollment	<ul style="list-style-type: none"> § Pregnant women whose pregnancy is the basis for Medicaid eligibility and pregnant women who are in their third trimester of pregnancy. <div data-bbox="542 1140 1248 1350" style="border: 1px solid black; background-color: #ffffcc; padding: 10px; margin: 10px 0;"> <p>If the mother of a newborn child is enrolled in a MHP at the time of the child’s birth, the newborn child is automatically enrolled in that health plan. Health plan responsibilities begin at the time of the child’s birth. (Refer to Newborn Child Eligibility Section of this chapter for more information.)</p> </div> <ul style="list-style-type: none"> § Migrants. § Native Americans.
Excluded Enrollment	<ul style="list-style-type: none"> § People without full Medicaid coverage (they receive emergency services only), or receive ABW. § People in Plus Care. § People who are dually Medicaid/Medicare eligible. § People for whom Medicaid is purchasing Medicare coverage (QMB, SLMB, ALMB). § People with Medicaid who reside in an ICF/MR or state psychiatric hospital. § People in the MDCH Traumatic Brain Injured residential rehabilitation program. § People receiving long term care in a licensed nursing facility. (Refer to Excluded Health Plan Services subsection for more information.)



- § People being served under the MIChoice Waiver (LOC Code 22).
- § People enrolled in the CSHCS Program.
- § Medicaid Deductible (**changed 7/1/05**) beneficiaries. (Refer to Medicaid Deductible (**changed 7/1/05**) Beneficiaries Section of this chapter for more information.)
- § People with commercial health plan coverage, including Medicare health plan coverage.
- § People in PACE (Program of All-Inclusive Care for the Elderly).
- § Children in foster care or child caring institutions.
- § People in the Refugee Assistance Program.
- § People in the Repatriate Assistance Program.
- § People who have been disenrolled from a Medicaid health plan due to actions inconsistent with plan membership.

If one member of a family is enrolled in the Children's Special Health Care Services (CSHCS) program, resides in a nursing facility, or loses Medicaid eligibility, this does not exempt the other family members from enrollment in a health plan.

9.2 MICHIGAN ENROLLS

Beneficiaries that are eligible to enroll in a MHP are covered for Medicaid services on a FFS basis until enrolled in a health plan.

Beneficiaries who are required or are eligible to enroll in a health plan have the opportunity to choose their health plan. They are given a pamphlet, Choosing Your Health Plan, which provides them information on this process. If no selection is made, the beneficiary is automatically enrolled with a health plan in the beneficiary's county of residence. Those beneficiaries automatically enrolled are identified on EVS by the acronym MCEP (Managed Care Enrollment Plan). The beneficiary has 90 days after assignment or choosing a health plan to change the health plan. After 90 days, the beneficiary is required to remain in the chosen health plan until the next open enrollment period.

The MDCH has contracted with MI Enrolls to:

- § Inform beneficiaries which physicians, pharmacies, and hospitals are part of each health plan.
- § Provide information to help the beneficiary choose a primary provider (a physician, nurse practitioner (NP), or physician's assistant who manages all of the beneficiary's health care).
- § Answer beneficiaries' questions regarding how to use the health plan.
- § Enroll beneficiaries in the health plan they choose or automatically enroll them in a health plan.



- § Change the beneficiary's health plan.
- § Provide a Request for an Administrative Hearing and Instructions form (DCH-0092).
- § Provide a Medical Exception Request form (MSA-1628) for medical exception from Managed Care.
- § Provide Beneficiary Complaint form (MSA-0300).

(Refer to the Directory Appendix for MI Enrolls contact information.)

9.3 MEDICAL EXCEPTIONS TO MANDATORY ENROLLMENT

The intent of the medical exception process is to preserve continuity of medical care for a beneficiary who is receiving active treatment for a serious medical condition from an attending physician (MD or DO) who would not be available to the beneficiary if the beneficiary is enrolled in a MHP. The medical exception may be granted on a time-limited basis necessary to complete treatment for the serious condition. The medical exception process is only available to a beneficiary who is not yet enrolled in a MHP, or who has been enrolled for less than two months. MHP enrollment would be delayed until one of the following occurs:

- § The attending physician completes the current ongoing plan of medical treatment for the patient's serious medical condition, or
- § The condition stabilizes and becomes chronic in nature, or
- § The physician becomes available to the beneficiary through enrollment in a MHP

If the treating physician can provide service through a MHP that the beneficiary can be enrolled in, then there is no basis for a medical exception to managed care enrollment.

If a beneficiary is enrolled in a MHP, and develops a serious medical condition after enrollment, the medical exception does not apply. The beneficiary should establish relationships with providers within the plan network who can appropriately treat the serious medical condition.

9.3.A. DEFINITIONS

Serious Medical Condition	Grave, complex, or life threatening Manifests symptoms needing timely intervention to prevent complications or permanent impairment An acute exacerbation of a chronic condition may be considered serious for the purpose of medical exception.
Chronic Medical Condition	Relatively stable Requires long term management Carries little immediate risk to health Fluctuates over time, but responds to well-known standard medical treatment protocols



Active Treatment	<p>Active treatment is reviewed in regards to intensity of services.</p> <p>The beneficiary is seen regularly, (e.g. monthly or more frequently), and</p> <p>The condition requires timely and ongoing assessment because of the severity of symptoms, the treatment, or both</p> <p>The treatment or therapy is extended over a length of time</p>
Attending/Treating Physician	<p>The physician (MD or DO) may be either a primary care doctor or a specialist whose scope of practice enables the interventions necessary to treat the serious condition.</p>
MHP Participating Physician	<p>A physician is considering participating in a MHP if he is in the MHP provider network or is available on an out-of-network basis with one of the MHPs with which the beneficiary can be enrolled. The physician may not have a contract with a MHP but may have a referral arrangement to treat the plan's enrollees. If the physician can treat the beneficiary and receive payment from the plan, then the beneficiary would be enrolled in that plan and no medical exception would be allowed.</p>

9.3.B. PROCESS FOR REQUESTING A MEDICAL EXCEPTION

The Medicaid beneficiary must initiate the review process for medical exception by completing Section I of the Medical Exception Request (form MSA-1628). Beneficiaries can obtain forms, discuss managed care options, or ask questions regarding the medical exception process by contacting MI Enrolls. (Refer to the Directory Appendix for contact information.) If the beneficiary has been enrolled in a MHP for more than two months, the medical exception request does not apply.

9.3.C. PHYSICIAN RESPONSIBILITY

The physician who is actively treating the beneficiary for the serious medical condition must complete Section II of the MSA-1628. If multiple physicians are involved, each one must complete a separate form. The physician completing the form must be actively treating the beneficiary, and must not be participating with or have any arrangement with a MHP with which the beneficiary can be enrolled. The information provided by the physician must include:

- § A detailed description of the serious medical condition that is being treated, including the diagnosis and current active signs and symptoms in adequate detail to justify the degree of seriousness. Diagnosis alone is not sufficient.
- § The length of time that the beneficiary has been actively treated for this condition by the physician completing the form.
- § The treatment plan in place including any planned interventions and a list of all current and anticipated medications.
- § The frequency of visits
- § The anticipated length of time (in months) that the beneficiary will need this treatment



A medical exception request cannot be processed without all of the above information. MDCH will verify that the treating physician is not available in any MHP in which the beneficiary can be enrolled. If an exception to managed care enrollment is granted, the MDCH will identify a period of time, up to one year, for which it is approved. At the end of that period, the beneficiary will be eligible for enrollment in a MHP.

9.4 IDENTIFIED ON EVS

EVS indicates the following for a beneficiary in a MHP:

- § LOC Code 07.
- § The message "HMO ENROLLEE".
- § The name of the health plan.
- § The telephone number of the health plan.

9.5 HEALTH PLAN MEMBERSHIP

Once enrolled in a health plan, that health plan sends member information to the beneficiary. The appropriate LOC code is entered on EVS with the name and toll-free telephone number of the MHP. The beneficiary also receives a membership card from the health plan.

9.6 COVERED HEALTH PLAN SERVICES

Services may be provided directly by the health plan or arranged through the health plan. Coverages include current Medicaid-covered services and any additional services the health plan may decide to provide that may not be Medicaid-covered services, other than excluded services listed below.

9.7 EXCLUDED HEALTH PLAN SERVICES

Services are either included or excluded from the health plan's monthly capitation rate. The following services are not included in the monthly capitation rate and may be provided by an enrolled provider who would be directly reimbursed by Medicaid.

- § Dental services for Provider Type 12 or 74. (Oral surgeons providing services as Provider Type 10 are included in the health plan's capitation rate and should follow health plan authorization rules.)
- § Nursing facility (NF) services. The health plan is responsible for providing up to 45 days of restorative health care in a nursing facility. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The provider may bill Medicaid after the disenrollment is processed.
- § Mental health services in excess of 20 outpatient mental health visits each contract year.
- § Services provided to persons with developmental disabilities and billed through the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).
- § Substance abuse treatment services.



- § Inpatient hospital psychiatric services and outpatient partial hospitalization psychiatric services.
- § Personal care authorized through DHS.
- § School-based services.
- § Pharmacy and related services prescribed by providers under the State's contract for specialty behavior services.
- § Private Duty Nursing (PDN) services, for beneficiaries under 21 years. (Beneficiaries over 21 may receive PDN services through the Habilitation/Support or MIChoice waiver programs.)

9.8 HEALTH PLAN AUTHORIZATIONS

The health plan must provide or arrange for services covered by the plan. Services that are not covered by the health plan do not require the health plan's authorization. If providers render both a health plan covered and a health plan noncovered service, the health plan is responsible for providing/arranging and reimbursing for those health plan covered services. It is imperative that health plan providers obtain authorization from the health plan for plan-covered services.

For Medicaid-covered services:

- § Nonemergency care – health plan authorization is required before rendering the service.
- § Urgent care – health plan authorization is required before rendering the service.
- § Emergency care to the point of stabilization – no authorization is required. The health plan is responsible for reimbursement of the service. The provider must inform the health plan as soon as possible that emergency services were provided. Post-stabilization treatment requires health plan authorization before rendering the service.

If a service requires PA from a health plan and from MDCH (e.g., cosmetic surgery), the provider must obtain the authorization from the health plan but does not have to obtain a second PA from MDCH.

9.9 CO-PAYMENTS

Health plan beneficiaries may be charged a co-payment for pharmacy, podiatric, chiropractic, vision, or hearing services. The co-payment requirements and amounts may not exceed the Medicaid FFS co-payments. Providers should charge health plan members co-payment as directed by the health plan.

Dental services are not provided by health plans. They are provided on a FFS basis or through the Healthy Kids Dental Program. Dental providers should charge the beneficiary 21 years of age or older a co-payment, even if the beneficiary is enrolled in a health plan. (Refer to the Dental Chapter of this manual for additional information.)



9.10 BILLING

9.10.A. HEALTH PLAN MEMBERS

The health plan receives a monthly capitation fee for each Medicaid beneficiary enrolled in the plan as part of its contract with MDCH. Health plans and providers may not bill the beneficiary for services not authorized by the health plan unless the beneficiary was informed of his financial responsibility prior to receiving the service. Providers may bill Medicaid for a service that is excluded from the health plan contract, but Medicaid covered under FFS (e.g., dental services).

9.10.B. REFERRAL PROVIDERS

If the health plan refers a beneficiary to a provider for health plan covered services, the health plan is responsible for reimbursement of those services.

9.10.C. HEALTH PLAN AS A PRIVATE INSURANCE (OTHER INSURANCE CODE 89)

A beneficiary who has an existing private health plan through employment, spouse or other source cannot be enrolled in a MHP at the same time. MDCH disenrolls that beneficiary from the MHP.

There may be FFS beneficiaries who are enrolled with a health plan as a private insurance. For example, the provider receives a monthly capitation rate for a beneficiary covered by a private health plan policy (such as Blue Care Network). These beneficiaries are identified by Other Insurance Code 89 on EVS and a private health insurance name if on the Third Party Liability (TPL) file.

The monthly capitation payment must not be reflected on the Medicaid claim. In most instances, the provider is billing Medicaid for the co-payment amount only. Medicaid only reimburses the provider for the Medicaid fee screen or co-payment amount, whichever is less. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

If Medicaid's maximum allowable amount is less than the co-payment amount billed, the beneficiary or his representative may not be billed for the difference. The amount paid by Medicaid is considered as payment in full.



SECTION 10 – CHILDREN’S SPECIAL HEALTH CARE SERVICES

MDCH determines eligibility for the CSHCS Program. CSHCS provides medically necessary services to individuals who are eligible and apply under the following circumstances:

- § Persons under the age of 21 with one or more qualifying medical diagnoses.
- § Persons age 21 and older with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Medical eligibility must be established by MDCH before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of other CSHCS criteria. An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, ABW, Medicare or MICHild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and all eligibility criteria for the other applicable program.

10.1 COVERAGE

The CSHCS coverage is limited to specialty health care services for the treatment of the beneficiary's qualifying medical condition. CSHCS does not cover primary care, well child visits or immunizations. Those with additional coverage (e.g., Medicaid, MICHild) continue to receive their well child visits, immunizations, etc. through that source or coverage.

Dental interventions may be covered for certain qualifying diagnoses. Beneficiaries must receive services from a Medicaid-enrolled dentist/orthodontist. Services must be related to the qualifying diagnosis and authorized by CSHCS.

CSHCS does not cover the treatment service needs related to developmental delay, mental retardation, autism, psychiatric, emotional, behavioral or other mental health diagnoses. A beneficiary who has both CSHCS and Medicaid or CSHCS and MICHild benefits receives his Medicaid or MICHild covered mental health services from the local PIHP/CMHSP.

CSHCS does not cover substance abuse treatment services. A beneficiary who has both CSHCS and Medicaid or CSHCS and MICHild benefits receives his Medicaid or MICHild covered substance abuse treatment services from the local Coordinating Agency (CA).

10.2 IDENTIFYING CSHCS ON THE EVS

The EVS will indicate when a beneficiary is enrolled in CSHCS for the date of service (DOS) entered in the inquiry. It will also identify if the provider ID number entered to access the EVS is authorized to render CSHCS services for the beneficiary on that DOS. CSHCS beneficiaries receive services through the FFS system.

Note: Certain provider types (e.g., pharmacies, hearing and speech centers, hearing aid dealers, home health agencies, medical suppliers, durable medical equipment providers, and orthotics/prosthetics suppliers) do not require CSHCS authorization to serve BHP beneficiaries who have CSHCS covered diagnoses applicable to the services. Families are able to access these providers as they choose and the CSHCS qualifying diagnosis warrants.



10.3 BENEFICIARY REVIEWS

Beneficiaries may request a Department Review for denial of eligibility determinations/redeterminations and denial of services. They may contact their local health department (LHD) or the CSHCS Program through the Parent Participation Program Family Phone Line. (Refer to the Directory Appendix for contact information.)



SECTION 11 – APPLICATION FOR MEDICAL ASSISTANCE

If a person is potentially eligible for health care coverage, excluding CSHCS, but has not applied for assistance, an application form should be completed. If the person is unable to complete the application form and a relative, guardian, or other representative of choice is not available to complete the form on their behalf, then the hospital or NF may do so. The actual application form varies depending upon the situation presented (e.g., Healthy Kids, individual, family).

11.1 MEDICAID APPLICATION/REDETERMINATION

The Medicaid Application/Redetermination form (FIA-1171) form is used for most potentially eligible beneficiaries. It may be obtained from the local DHS office or by contacting DHS at the address noted in the Directory Appendix.

The combined Healthy Kids/MiChild application (DCH-0373-D) may be obtained by calling the MiChild toll-free number or through the MDCH website. The contact information is located in the Directory Appendix.

The Medicaid Patient of Nursing Home Application (FIA-4574) may be used as an alternative to the FIA-1171. The FIA-4574 is a Medicaid application/redetermination form used to determine Medicaid eligibility for the nursing facility patient only.

The application forms are self-explanatory. Questions regarding the forms should be referred to the local DHS office.

11.2 HEALTHY KIDS

The Healthy Kids/MiChild application (DCH-0373-D) may be used as an alternative to the FIA-1171. It is used to determine Medicaid eligibility only under the Healthy Kids categories for children under age 19 and pregnant women of any age. Persons can also apply for Healthy Kids/MiChild through the LHD or through the Internet as noted in the Directory Appendix.

The FIA-1171 must be used instead of the DCH-0373-D in the following situations:

- § The family needs/wants other types of assistance in addition to Medicaid (e.g., cash assistance [FIP], food stamps, emergency needs); or
- § Other family members need/want health care coverage. (In this case, the entire family must use the FIA-1171.)

The MiChild Renewal Form is considered a Medicaid application for a child who was receiving MiChild and, at redetermination, is now eligible for Healthy Kids Medicaid.

11.3 HOSPITALS AND NURSING FACILITIES

The person or his authorized representative should sign applications when possible. The local DHS office must determine Medicaid eligibility even if the beneficiary is receiving Supplemental Security Income (SSI) benefits. A beneficiary is not automatically eligible for Medicaid just because he has SSI benefits and resides in a NF.



For state-owned and -operated facilities, if the person is unable to sign and the authorized representative is not available, the Reimbursement Office's authorized representative may sign the application using his personal signature and position title.

If retroactive Medicaid eligibility is requested, in addition to the application form, the Retroactive Medicaid Application (FIA-3243) must be completed for each retroactive month that eligibility is requested.

11.4 INITIAL ASSESSMENT OF ASSETS

The local DHS office must make an initial assessment of an institutionalized or MIChoice waiver patient's assets upon request from that patient. The assessment should be requested even if the patient is not currently applying for Medicaid benefits. The assessment must be made from the date of admission to the facility.

An initial assessment is a determination of the total amount of countable assets owned by an institutionalized or MIChoice waiver patient and/or his spouse on a given day. The day is usually the day the patient was admitted to the NF or MIChoice waiver.

Nursing Facilities are required to notify patients, their families, or authorized representatives of the need to request the initial assessment in case of future Medicaid application. The Asset Declaration - Nursing Home Resident and Spouse (FIA-4574B), is to be completed by the patient and submitted to the local DHS office to request that an initial assessment be completed. The facility may assist the patient with the completion of this form. Any questions regarding the form, or requests for copies of the form, should be directed to the local DHS office.

The patient may refuse to complete the assessment, but it should be stressed that it is easier to obtain the assessment at the time of admission than it is to try to recreate the situation at a future date.



SECTION 12 – ELIGIBILITY DETERMINATION OF INSTITUTIONAL CARE

12.1 FACILITY ADMISSION NOTICE

In addition to the Assistance Application/Redetermination (FIA-1171), the Facility Admission Notice (MSA-2565-C) is used by institutional providers to notify the local DHS office of the admission of a beneficiary or potentially eligible Medicaid beneficiary. It should be submitted even if Medicare or other insurance covers the person's stay. (Refer to the Forms Appendix for a copy of the form.)

12.1.A. HOSPITALS AND NURSING FACILITIES

The MSA-2565-C must be completed by facility personnel and signed by the beneficiary or his authorized representative. When a Hospice beneficiary enters a nursing facility, the MSA-2565-C should state Hospice in the Remarks section.

The facility must retain the original of the MSA-2565-C in the beneficiary's file. A copy must be sent to the local DHS office. The DHS returns a copy of the MSA-2565-C to the facility noting the eligibility status and the beneficiary's patient pay amount.

12.1.B. STATE-OWNED AND -OPERATED FACILITIES AND CMHSP FACILITIES

If no authorized representative is available, an authorized representative of the facility's Reimbursement Office may sign the MSA-2565-C on behalf of the beneficiary. The representative must use his personal signature and position title.

A copy of the MSA-2565-C (and the completed FIA-1171, if necessary) must be forwarded to the local DHS office as soon as possible following admission.

The MSA-2565-C is generally self-explanatory. The facility should contact the local DHS office with any questions regarding completion of this form.

For state-owned and -operated facilities, the following instructions apply:

- § Item 13: attending physician - This item may be left blank.
- § Item 19: if NF, specify per diem rate. The facility should enter its private pay routine nursing care per diem rate to facilitate determination of Medicaid eligibility.

Medicaid does not pay the facility services rendered if:

- § The returned copy of the MSA-2565-C indicates the person is not eligible for Medicaid.
- § The person has a divestment penalty (LOC Code 56).



12.2 PATIENT PAY AMOUNT

12.2.A. NURSING FACILITY DETERMINATIONS

After the Medicaid application and MSA-2565-C have been submitted, the local DHS office determines eligibility for medical assistance. All allowable expenses and income are calculated, and any remaining income is considered excess income. Such excess income is then considered in determining the amount the beneficiary must pay toward his medical expenses each month. This monthly contribution by the beneficiary toward his care is called the patient pay amount.

The following forms are utilized to notify the facilities of patient pay and eligibility information:

- § FIA-3227 – If the local DHS office is unable to determine final eligibility status within five working days of receipt of the application for medical assistance, the Tentative Patient Pay Amount Notice (FIA-3227) is sent to the facility as notification of the person's tentative patient pay amount. When the final determination is made, a copy of the MSA-2565-C is returned to the facility.
- § FM-160 – At the end of each month, MDCH mails to each NF provider a list of his residents with LOC Code 02. The LTC Eligibility List (FM-160 Report) is generated from the Medicaid Management Information System (MMIS). This list is sorted by provider ID number, and shows eligibility, authorization, LOC, and patient pay information for each resident for the following month.

The identity of residents in each facility is determined from the provider ID number entered on the MSA-2565-C submitted at admission or re-admission. It is very important that providers ensure that their provider ID numbers are current and correct.

The FM-160 Report should be used in preparation of bills for services provided in that month. This avoids many billing problems stemming from eligibility information. The facility may contact the resident's local DHS office as identified on EVS if information on the FM-160 is incorrect.

In case of nonreceipt of the FM-160 or for answers to billing questions, the provider should call MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Facilities are responsible for collecting the patient pay amount. If the facility receives the FIA-3227, it indicates a tentative patient pay amount to be collected by the facility. The patient pay amount is not prorated for partial months. This amount is subject to change as the beneficiary's financial eligibility changes. The patient pay amount must be exhausted before any Medicaid payment is made.

A beneficiary who has a patient pay amount cannot legally be charged more than the Medicaid rate for a short stay in a facility. For example, if a beneficiary is in a long term care facility for two days in a month, the provider must collect no more than the Medicaid rate for two days from the patient pay amount (even if the patient pay amount



is great enough to cover the higher private pay rate). The balance, or unused portion, of the patient pay amount must be returned to the beneficiary or his family.

For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows NF beneficiaries to use their patient pay amount to obtain these services. For additional information, the facility may contact the MDCH, Long Term Care Services. (Refer to the Directory Appendix for contact information.)

12.2.B. HOSPITALS

Hospitals are not notified of a tentative patient pay amount via the FIA-3227. The hospital may obtain the patient pay amount by:

- § Waiting for the **mihealth** card to be issued to the beneficiary or verifying eligibility using the EVS.
- § Submitting a claim to MDCH. (Medicaid deducts the patient pay amount and the claim is processed accordingly.)
- § Contacting the local DHS office.

12.2.C. STATE-OWNED AND -OPERATED FACILITIES/PIHPs/CMHSPs

MDCH or the PIHP/CMHSP determines a financial liability, or ability to pay, separate from the DHS patient pay amount. The ability to pay may be an individual, spouse, or parental responsibility. It is determined and reviewed as required by the Mental Health Code. The beneficiary or his authorized representative is responsible for the ability to pay amount, even if the patient pay amount is greater.

12.3 PREADMISSION SCREENING

If a beneficiary is to be transferred from an acute care hospital to a NF, preadmission screening for mental illness/mental retardation must be completed prior to transfer.



COORDINATION OF BENEFITS

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SECTION 1 - INTRODUCTION

This chapter applies to all providers.

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program/Coordination Agency (CMHSP/CA), that entity is responsible for the Medicaid payment liability.

Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. The terms third party liability and other insurance are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. 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 Community Health (MDCH).

Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

1.1 SUBROGATION

When a beneficiary has a third party resource available, Medicaid has the legal right to subrogation. Federal regulations grant Medicaid the right of recovery for any amounts payable to Medicaid. In order to recover the conditional payment, MDCH may bring direct action in its own right against the entity responsible for payment or against any other entity that has received payment. To be eligible for Medicaid, beneficiaries must assign to MDCH the right to collect other insurance payments on their behalf.

1.2 VERIFICATION OF OTHER INSURANCE

Information about a beneficiary's other insurance is available through the automated Eligibility Verification System (EVS). It is not displayed on the **mihealth** card. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information, and the Directory Appendix for contact information.)

Providers should always ask the beneficiary if other insurance coverage exists at the time of service. If the beneficiary identifies other insurance coverage that is not listed on the EVS, the provider must use that other insurance and report it to MDCH by contacting the Medicaid Provider Inquiry Line or Third Party Liability Section. If the beneficiary belongs to a network, the provider must refer him to that preferred provider for services needed. (Refer to the Directory Appendix for contact information.)



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If the beneficiary does not agree with the other insurance information contained in the EVS (e.g., other insurance coverage is no longer available), the beneficiary should be instructed to notify his local Department of Human Services (DHS) office of the change, or the provider may contact the Medicaid Provider Inquiry Line or Third Party Liability Section to initiate a change in the EVS. (Refer to the Directory Appendix for contact information.)



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SECTION 2 - CATEGORIES OF OTHER INSURANCE

The major categories of other insurance are:

- § Commercial health insurance carriers (including managed care carriers [MCC], preferred provider organizations [PPO], point of service organizations [POS], health maintenance organizations [HMO]) and traditional indemnity policies
- § Auto Insurance (accident, no-fault)
- § Workers' Disability Compensation
- § Court-Ordered Medical Support
- § General Liability Insurance
- § Medicare

2.1. COMMERCIAL HEALTH INSURANCE

If a Medicaid beneficiary is enrolled in a commercial health insurance plan, the rules for coverage by the commercial health insurance must be followed. This includes, but is not limited to:

- § Prior authorization (PA) requirements.
- § Provider qualifications.
- § Obtaining services through the insurer's provider network.

Beneficiaries must use the highest level of benefits available to them under their policy. Medicaid is not liable for payment of services denied because coverage rules of the commercial health insurance were not followed. For example, Medicaid does not pay the point of service sanction amount for the beneficiary electing to go out of the preferred provider network. Medicaid is, however, liable for Medicaid-covered services that are not part of the commercial health insurance coverage.

PA is not necessary for situations of other insurance coverage if all of the following apply:	PA is required for the following:
<ul style="list-style-type: none"> § The beneficiary is eligible for the other insurance and the primary insurer rules are followed; § The provider is billing a standard Health Care Financing Administration Common Procedure Coding System (HCPCS) code that Medicaid covers and the primary insurer makes payment or applies the service to the deductible; and § The service/item complies with Michigan Medicaid standards of coverage as described in this manual. 	<ul style="list-style-type: none"> § PA is required for cases where the commercial carrier benefit has been exhausted or the service/item is not a covered benefit. § PA is necessary for all other situations, including not otherwise classified (NOC) codes.

Inappropriately recoded claims are rejected by MDCH even if MDCH issued PA.



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MDCH payment liability for beneficiaries with private commercial health insurance is the lesser of the beneficiary's liability (including coinsurance, co-payments, or deductibles), the provider's charge, or the maximum Medicaid fee screen, minus the insurance payments and contractual adjustments. (A contractual adjustment is an amount established in an agreement with a third-party payer to accept payment for less than the amount of charges.)

Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered payment-in-full for services rendered. Neither the beneficiary nor MDCH has any financial liability in these situations.

Providers must secure response(s) from other insurances (e.g., explanation of benefits, denials) prior to billing Medicaid except for the fixed co-pay amounts or payments for noncovered services. In these cases, providers must have documentation in the beneficiary's file. When billing on paper, this documentation must be submitted as an attachment to the paper claim. When billing electronically, no attachment is necessary, as all required data must be included in the electronic submission. (Refer to the Billing & Reimbursement Chapters of this manual for further information.)

If payments are made by another insurance carrier, the amount paid, whether it is paid to the provider or the beneficiary, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the beneficiary if the other insurance pays the beneficiary directly. It is acceptable to bill the beneficiary in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the other insurance. Failure to repay, return, or reimburse Medicaid may be construed as fraud under the Medicaid False Claim Act if the provider has received payment from a third party resource after Medicaid has made a payment. Medicaid's payment must be repaid, returned, or reimbursed to MDCH Third Party Liability Section. (Refer to the Directory Appendix for contact information.)

2.2. AUTOMOBILE INSURANCE (ACCIDENT, NO-FAULT)

Under Michigan's no-fault law, automobile insurance carriers are required to pay the medical expenses for injuries incurred in an automobile accident. However, in some instances, the insured's automobile policy contains a rider stating that his health insurance coverage takes priority over the automobile insurance carrier's policy. (This also applies to Coordination of Benefits riders.) In situations where more than one individual is involved in an accident, there is a possibility that multiple automobile insurance carriers are involved. As a result, the liable insurance carrier cannot always be readily identified at the time of initial medical treatment. The no fault law is designed to designate an order of priority of liability. Providers must bill the automobile insurance carrier prior to billing Medicaid.

The order of responsibility to pay for medical expenses for automobile accidents is as follows:

- § The insurance company of the injured party regardless of whether he was in his, or any, automobile.
- § The insurance company of any resident relative of the house in which the injured party also resides.
- § The insurer of the owner of the vehicle occupied. For nonoccupants (pedestrians) of the vehicles, the insurer of the vehicles involved.



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- § The insurer of the driver of the vehicle occupied. For nonoccupants (pedestrians) of the vehicles, the insurer of the drivers involved.

If a claim has been filed, providers should bill Medicaid while the other insurance claim is pending resolution. Medicaid must be billed within six months from the date of filing the no fault claim to keep the claim active with Medicaid. Providers must bill the appropriate procedure code, date of the accident, and any other pertinent information (e.g., the identification of the other insurance of the injured party) on the claim.

Providers may directly pursue no-fault or other casualty cases and submit claims directly to the other insurance carriers. If liability is in question, Medicaid may be billed. Medicaid then pursues reimbursement from the other insurance through subrogation.

2.3. WORKERS' DISABILITY COMPENSATION

Workers' Disability Compensation is a system established under state law that provides payments, without regard to fault, to employees injured in the course of their employment. Workers' Disability Compensation does not cover medical care incidental to or separate from the injury. Providers must establish if the beneficiary is covered by Workers' Disability Compensation.

If a claim has been filed and is contested, providers may bill Medicaid while the claim is pending resolution by Workers' Disability Compensation. The provider must bill the appropriate procedure code, the date the claim was submitted (if known), and any other pertinent information (e.g., employer, Workers' Disability Compensation carrier, and attorney's name). Medicaid may bill the compensation carrier, or may follow up in hearings as to redemption or settlement.

2.4. COURT-ORDERED MEDICAL SUPPORT

Court-ordered medical support is medical coverage for beneficiaries that the court has ordered to be paid by an individual (who is also the policyholder) other than the beneficiary. This individual could be an absent parent, a grandparent, adoptive parent, etc. The provider must pursue recovery of the other insurance payment directly from the policyholder. In instances where the policyholder does not reside with the beneficiary (e.g., an absent parent), providers are encouraged to have the custodial parent obtain a Qualifying Medical Support Order through the local Friend of the Court. This allows the provider to bill the other insurance directly (e.g., Blue Cross/Blue Shield). If there is not a Qualifying Medical Support Order on file for the beneficiary, providers must still obtain the other insurance payment from the policyholder. (Refer to the Directory Appendix for contact information.)

2.5. GENERAL LIABILITY

General liability insurance is coverage that generally pertains to claims arising out of the insured's liability for injuries or damage caused by the ownership of property, manufacturing operation, contracting operations, sale or distribution of products, or the operation of machinery, as well as professional services. If the beneficiary's injury is not work- or automobile-related, the beneficiary's medical services may be covered by another insurance carrier (e.g., homeowner's insurance policy). This insurance carrier is considered primary and must be billed according to the rules of the insurance carrier.



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2.6. MEDICARE

2.6.A. MEDICARE ELIGIBILITY

Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, that provider must also accept the individual as a Medicaid beneficiary.

If a Medicaid beneficiary is eligible for Medicare (65 years old or older) but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to Medicaid as long as all program policies (such as time limit for claim submission) have been met.

Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- § Sixty-five years of age or older.
- § A disabled adult (entitled to SSI or RSDI due to a disability).
- § A disabled minor child.

2.6.B. MEDICARE PART A

Since Medicare Part A pays for care in an inpatient hospital, nursing facility (NF), services provided by a home health agency (HHA) or in other institutional settings, Medicaid's reimbursement for services under Medicare Part A may vary.

If MDCH is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDCH also pays the beneficiary's Medicare Part A premium.

MDCH monitors beneficiary files to identify all beneficiaries who currently have Medicare Part B coverage only, and have Part B buy-in. Once these beneficiaries are identified, MDCH automatically processes Part A buy-in

When a beneficiary has incurred Medicare Part A charges and is eligible for, but does not have, Medicare Part A buy-in, the claim is rejected. Providers must wait for the beneficiary to obtain Medicare coverage, then bill Medicare for services rendered. After Medicare's payment is received, Medicaid should be billed for any coinsurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.

To expedite the buy-in process, providers may notify MDCH, in writing, when a beneficiary age 65 or older, covered by Medicare Part B only, is admitted to an inpatient hospital. (Refer to the Directory Appendix for Medicare Buy-In Unit contact information.)



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The following information is required:

- § Beneficiary's name, date of birth, and Medicaid identification (ID) number;
- § Health insurance claim number (HICN);
- § Inpatient hospital admission date; and
- § Hospital name, address, and Medicaid provider ID number.

Special points to remember:

- § Medicaid does not pay for any portion of the services Medicare would have otherwise covered if a provider's error prevents Medicaid from buying-in Medicare Part A.
- § To bill a claim when Medicare Part A coverage for Medicare/Medicaid beneficiaries is exhausted prior to an admission or during an inpatient hospital stay, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.
- § To bill a claim when no Medicare payment has been made because the amount of Medicare coinsurance, plus the amount for lifetime reserve days, is greater than the Medicare diagnosis related group (DRG) amount, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.

2.6.C. MEDICARE PART B

Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. When a beneficiary is eligible for and enrolled in Medicare Part B, Medicare usually pays for a percentage of the approved Medicare Part B allowable charges and Medicaid pays the applicable deductible and/or coinsurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.

Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary. After the beneficiary's death, DHS is responsible for making the application to the Social Security Administration (SSA) to cover medical services provided prior to the death.

2.6.D. MEDICARE BUY-IN

If a beneficiary is eligible for Medicare but has not enrolled, he can do so at any time throughout the year through buy-in. If the beneficiary is unable to pay the Medicare premiums, Medicaid may pay the premiums through a contractual agreement (called the Medicare Buy-In Agreement) with the SSA. However, Medicaid cannot buy-in for the beneficiary until they apply for Medicare and the SSA is aware that they are Medicaid-eligible.



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Some dual-eligible beneficiaries are classified as:

Qualified Medicare Beneficiaries (QMB)	Medicaid pays Medicare Parts A and B premiums for these individuals, and reimburses providers for Medicare coinsurance and/or deductible amounts only to the extent that the total payment does not exceed the Medicaid maximum allowable amount. These beneficiaries are identified by scope/coverage code 2B. Physicians and suppliers should be aware that services provided to QMBs are reimbursed on a Medicare assignment basis only. If a provider knowingly bills for Medicare services on other than an assignment basis, the Federal Department of Health and Human Services (HHS) can seek sanctions.
Specified Low Income Medicare Beneficiaries (SLM/SLMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid does not reimburse providers for any services rendered to the beneficiary. No mihealth card is issued to these individuals.
Additional Low Income Medicare Beneficiaries (ALMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid does not reimburse the provider for any services rendered to the beneficiary. No mihealth card is issued to these individuals.

2.6.E. MEDICAID LIABILITY [CHANGES MADE 7/1/05]

If Medicare has paid 100 percent of the allowable charges and there is no coinsurance involved, then Medicaid has no payment liability.

Neither the beneficiary nor Medicaid is liable for any difference in the amount billed by the provider and Medicare's allowable fee.

If the beneficiary is in a Medicare Risk HMO, MDCH pays fixed co-pays on the services up to the lesser of Medicaid's allowable amount for the service or the beneficiary's payment liability, as long as the rules of the HMO are followed.

The MDCH payment liability for beneficiaries with Medicare coverage is the lesser of:

- § The beneficiary's liability for coinsurance, copayments, and/or deductibles minus any applicable Medicaid copayment, patient pay, or deductible (changed 7/1/05) amounts
- § The Medicaid fee screen/allowable amount minus any Medicare payments, contractual adjustments, and any applicable Medicaid copayment, patient pay, or deductible (changed 7/1/05) amounts.
- § The provider's charge minus any Medicare payments, contractual adjustments, and any applicable Medicaid copayment, patient pay, or deductible (changed 7/1/05) amounts.

If Medicare has not paid the Medicare portion of a Medicare-covered service for a beneficiary enrolled in Medicare Part B, MDCH rejects the claim.



Medicare coverage is not available for a Medicaid beneficiary who is 65 years or older and is an alien who has been in the country less than five consecutive years.

When a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B, MDCH rejects any claim for Medicare Part B services. Providers should instruct the beneficiary to pursue Medicare through the SSA.

If Medicare reimburses for the service, Medicaid does not require PA for the service.

Approximately twice per year, MDCH issues an MW-861 Report which identifies beneficiaries who are retroactively eligible for Medicare. Medicaid payment for services provided to these beneficiaries is adjusted to recoup all monies except the Medicaid liability, and recovered via an automated claim adjustment. Providers are notified when these adjustments occur. Providers should refer to the MW-861 Report for beneficiary details. If a discrepancy in payment exists, the provider should contact the Provider Inquiry or Third Party Liability staff. (Refer to the Directory Appendix for contact information.)

Beneficiaries cannot be charged for Medicaid-covered services, except for approved co-pays or deductibles, whether they are enrolled as a fee-for-service (FFS) beneficiary, or MDCH is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP or CA capitation.

2.6.F. EXCEPTIONS TO THE BILLING LIMITATION

When a delay in payment from Medicare causes a delay in billing Medicaid, an exception may be made if the provider can document that Medicare was billed within 120 days of the date of service and Medicaid was billed within 120 days of the date of payment or rejection by Medicare. Medicaid payment is made provided all other requirements (e.g., beneficiary eligibility, medical necessity) are met. A copy of the Medicare claim submitted and Medicare's response must be attached to the Medicaid paper claim to document Medicare's delay. If billing electronically, a note should be added in the Remarks segment that the late billing is due to Medicare's delay in processing the claim. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

2.6.G. SPECIAL CONSIDERATIONS FOR INPATIENT HOSPITAL CLAIMS

Due to the nature of DRG calculations, the following instructions must be used when completing an inpatient hospital claim:

- § All Medicare and other insurance payment information should be indicated on the claim that contains the Patient Status code that indicates the beneficiary has been discharged from the facility. If the inpatient service requires two claims, payment information (e.g., total other insurance payment, Medicare coinsurance and deductible) must be included



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on the claim for the last date of service for the inpatient stay. Interim claims should not reflect a payment.

- § Medicare Part A and Part B charges must be combined on one claim.
- § The actual total Medicare Part A and Part B payment, which includes contractual adjustment, must be indicated on the inpatient hospital claim/adjustment. This amount is not the contract charge. The amount billed may equal both the sum of the coinsurance and deductible amounts; however, in order to provide proper reimbursement, the actual total Medicare Part A and Part B payment must be indicated.
- § When a beneficiary has Medicare Part B only, this must be reflected in the Remarks Section of the claim. Additionally, the claim must reflect the 20 percent amount due from Medicaid. The Medicare Part A and Part B payment is the 80 percent of the allowable charges covered by Medicare for Part B services.

For Medicare reimbursement, the amount billed for services does not equal the sum of the coinsurance and deductible items. It must be calculated as the gross hospital charges **minus** all Medicare payments, **minus** other insurance payments, and **minus** any patient-pay and/or co-payment amount. If a claim is submitted with the amount billed equal to zero, other payment greater than or equal to Medicaid's payment, or a negative amount, Medicaid does not make a payment. If there is a balance to be billed to Medicaid, the hospital may bill Medicaid for covered services only.

2.6.H. LIFETIME RESERVE DAYS

Medicare allows a one-time additional 60 days of coverage known as Lifetime Reserve Days (LRD). A Medicaid beneficiary who has Medicare Part A must use these 60 days before Medicaid makes a payment, except for deductibles and coinsurance.

2.6.I. OUTPATIENT HOSPITAL LABORATORY SERVICES

Medicare pays most diagnostic and clinical laboratory tests at 100 percent. Therefore, Medicaid has no payment liability.

2.6.J. PSYCHIATRIC SERVICES

Diagnostic outpatient hospital psychiatric physicians services, including the initial psychiatric diagnostic and evaluation interview, family counseling and psychological testing, are reimbursed as a Medicare Part B service.

Medicare Part B reimbursement for therapeutic outpatient hospital services is different than reimbursement for other Part B services.

Medicare applies a special 37.5 percent fee reduction to the amount approved by Medicare. (The 37.5 percent fee reduction does not appear on the Medicare EOB.) Medicaid is liable for the 37.5 percent fee reduction, the annual Part B deductible, and the 20 percent coinsurance amount, up to the Medicaid maximum allowable amount.



2.6.K. OTHER INSURANCE CARRIER ID LIST

The Other Insurance Carrier ID List on the MDCH website provides a listing of codes assigned by MDCH for each insurance carrier. (Refer to the Directory Appendix for contact information.) The list is available by carrier code and by carrier name and is updated quarterly. All third-party carriers must be used to the fullest extent possible, prior to billing Medicaid and Children's Special Health Care Services (CSHCS) Programs, including Medicaid Health Plans (MHPs) and PIHPs/CMHSPs/CAs.

Major carriers (e.g., Blue Cross/Blue Shield, AETNA) are listed by the Other Insurance Code with the home offices first, usually followed by the district offices. Providers should submit the other insurance claims to the nearest office. If the provider is in doubt, claims should be sent to the home office of the carrier.



SECTION 3 - SPECIAL CONSIDERATIONS

3.1 MASTER MEDICAL

All insurance coverage, including Master Medical policy riders, must be used before filing a claim with Medicaid. If the beneficiary has a Master Medical policy rider (e.g., Blue Cross/Blue Shield), providers must identify whether the provider or policyholder must bill. If the policyholder must bill, the provider must provide a statement of charges to the beneficiary or policyholder to use when billing Master Medical. If there is a court order for medical support that includes Master Medical, the custodial parent may obtain a qualified medical support order for providers to be paid directly from the insurance carrier. Whether the payment is made to the policyholder or the provider, the provider must report it as other insurance payment on the bill submitted to Medicaid. Providers must pursue recovery of the insurance payment if it is made directly to the policyholder. The beneficiary, or his representative, must not be billed for this payment unless the beneficiary is the policyholder.

3.2 COINSURANCE/DEDUCTIBLE AND/OR CO-PAYMENT

Medicaid responsibility for payment of coinsurance/deductible and co-payment amounts is:

Co-pay	Medicaid pays fixed co-pay amounts up to the Medicaid-allowable amounts as long as the rules of the other insurance are followed. The provider must bill the fixed co-pay amount as the charge.
Coinsurance and deductible	Medicaid pays the appropriate coinsurance amounts and deductibles up to the beneficiary's financial obligation to pay or the Medicaid allowable amount (less other insurance payments), whichever is less. If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid cannot be billed.
Medicaid services not covered by another insurance	If the other insurance does not cover a service that is a Medicaid-covered service, Medicaid reimburses the provider up to the Medicaid allowable amount if all the Medicaid coverage rules are followed.

MDCH cannot be billed for co-pays, coinsurance, deductibles, or any fees for services provided to beneficiaries enrolled in a MHP, or who are receiving services under PIHP/CMHSP/CA) capitation. Beneficiaries are responsible for payment of all co-pays and deductibles allowed under the MHP/PIHP/CMHSP/CA contract with MDCH. If the beneficiary with other insurance coverage is enrolled in a MHP or receiving services under a PIHP/CMHSP/CA capitation, the MHP/PIHP/CMHSP/CA assumes the Medicaid payment liabilities.

Beneficiaries cannot be charged for Medicaid-covered services, except for approved co-pays or deductibles, whether they are enrolled as a FFS beneficiary, or MDCH is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP/CA capitation.

(Refer to the Medicaid Liability subsection of this chapter for additional information on Medicare claims.)



3.3 CLAIM REPLACEMENT

A claim replacement should be submitted if another insurance makes a payment subsequent to Medicaid's payment. (For specific claim replacement instructions, refer to the Billing & Reimbursement Chapters of this manual.)



SECTION 4 – CROSSOVER CLAIMS [SECTION ADDED 7/1/05]

(Section added 7/1/05 per bulletins AP 04-05 and MSA 05-02)

The crossover process allows providers to submit a single claim for individuals dually eligible for Medicare and Medicaid, or qualified Medicare beneficiaries eligible for Medicaid payment of co-insurance and deductible to the Medicare carriers Wisconsin Physician Service (WPS) or AdminaStar, and have it also processed for Medicaid reimbursement.

Additional information about the crossover claim process is available on the MDCH website. (Refer to the Directory Appendix for website information.)

4.1 ACCEPTABLE CROSSOVER CLAIMS

MDCH accepts Medicare Part B professional claims processed by WPS and AdminaStar when submitted in the ASC X12N 837P version 4010A1 claim format for the following types of providers:

WPS	Ambulance, Certified Registered Nurse Anesthetists*, Certified Nurse Midwives*, Certified Nurse Practitioners*, Chiropractors, Independent Laboratories, Medical Clinics, Oral Surgeons, Physical Therapists*, Physicians, and Podiatrists * When in private practice and directly enrolled with MDCH.
AdminaStar	Medical Suppliers, Orthotists, Prosthetists If AdminaStar processes Part B claims for other types of providers (e.g. physician services) or vision claims, these will also be part of the crossover process to MDCH.

When a claim is crossed over to MDCH, a remittance advice (RA) will be generated from WPS or AdminaStar with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark does not appear on the WPS or AdminaStar RA, a separate claim will have to be submitted to MDCH.

4.2 CLAIMS EXCLUDED FROM CROSSOVER PROCESS

The following types of claims will be **excluded** from the crossover process between MDCH and WPS and AdminaStar:

- § Totally denied claims
- § Claims denied as duplicates or missing information
- § Replacement claims or void/cancel claims submitted to Medicare
- § Claims reimbursed 100 percent by Medicare
- § Claims for dates of service outside the beneficiary's Medicaid's eligibility begin and end dates
- § Part B claims from any Medicare carrier other than WPS or AdminaStar

Providers must resolve denied claims with WPS or AdminaStar unless the service is an excluded benefit for Medicare, but covered by Medicaid (e.g., insertion of an IUD or hearing aid supply). In those cases,



the excluded Medicare service can be billed directly to MDCH. Providers must submit Part B claims from any Medicare carrier other than WPS or AdminaStar, and any claims Medicare has adjusted, directly to MDCH.

4.3 SPECIAL INSTRUCTIONS FOR CROSSOVER CLAIMS

Providers must include their Medicaid provider ID number, along with their Medicare provider ID number, on the claim sent to Medicare. The Medicaid ID must be reported by repeating Loop ID 2010AA REF01 and REF02 in the 837P version 4010A1. The information must be entered as follows:

- § Loop ID 2010AA REF01: enter "1D" for Medicaid
- § Loop ID 2010AA REF02: enter the 9-digit Medicaid provider ID number (2-digit provider type followed by the 7-digit number)

If the Medicaid information is not included in the claim sent to Medicare, MDCH will not be able to process the claim.

Once payment is received from Medicare and the MA07 remark code appears on the Medicare RA, appearance of the claim on the Medicaid RA should be expected within 30 days. Claims not appearing within that time should be submitted directly to MDCH showing all Medicare payment information.



BILLING & REIMBURSEMENT FOR DENTAL PROVIDERS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers billing the ADA-2000 or 837 Dental claim formats. It contains information needed to submit dental claims to the Michigan Department of Community Health (MDCH) for Medicaid and Children’s Special Health Care Services (CSHCS). It also contains information about how claims are processed and how providers are notified of MDCH actions.

Dental providers must use the ASC X12N 837D 4010 A1 dental format when submitting electronic claims and the ADA 2000 claim form for paper claims.

1.1 CLAIMS PROCESSING SYSTEM

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

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

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

1.2 REMITTANCE ADVICE

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

1.3 ADDITIONAL RESOURCE MATERIAL [CHANGE MADE 7/1/05]

Additional information needed to bill may include:

Bulletins	These intermittent publications supplement the provider manual. Bulletins are automatically mailed to enrolled providers affected by the bulletin and to subscribers of the manual(s). Recent bulletins can be found on the MDCH website. (Refer to Directory Appendix for contact information.)
CDT Codes (changed 7/1/05)	Providers must purchase this manual from the American Dental Association. For ordering information and catalog, contact the ADA. (Refer to the Directory Appendix for contact information.)



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Companion Guide (Data Clarification Document)	This document is intended as a companion to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim, ASC X12N 837D 4010A1. It contains data clarifications and identifiers to use when a national standard has not been adopted and parameters in the implementation guide that provide options.
Electronic Submission Manual	This manual provides detailed instructions on obtaining approval for electronic billing and how to file electronic claims to MDCH. It is available on the MDCH website. (Refer to the Directory Appendix for contact information.)
Databases	These list procedure codes, descriptions, fee screens, and other pertinent coverage, documentation, and billing indicators. The databases are only available on the MDCH website. (Refer to Directory Appendix for contact information.)
Numbered Letters	General program information or announcements are transmitted to providers via numbered letters. These can be found on the MDCH website. (Refer to Directory Appendix for contact information.)
Provider Manual	This manual includes program policy and special billing information. Provider manuals and other program publications are available at a nominal cost from MDCH. (Refer to the Directory Appendix for information on ordering manuals and publications.)

1.4 ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Management and Budget website. (Refer to the Directory Appendix for contact information.)



SECTION 2 – GENERAL INFORMATION/PRIOR AUTHORIZATION [CHANGE MADE 7/1/05]

The Dental Prior Approval Request Authorization (PA) Request (MSA-1680-B) is a form designed to obtain authorization for those services that require PA, as indicated in the Dental Chapter and the Dental Procedure Code Database on the MDCH website. (Refer to the Directory Appendix for website information.)

The dentist must remember the following:

- § X-rays must be sent along with the PA form. (modified 7/1/05)
- § The PA form only needs to include the procedure that requires PA.
- § Assess the general oral health and provide a five-year prognosis on the prosthesis requested.
- § The dentist should make liberal use of the Pertinent Dental History and Medical area on the request to better define symptomatology, treatment situations, etc. when the services requested or the accompanying documentation may leave unresolved questions. When health problems exist, they should be identified on the request along with any effect they might have upon the proposed plan of treatment.
- § Any additional documentation submitted with the request must contain the beneficiary's name and identification (ID) number, date, and the dentist's name and ID number.

Additional information is generally required to be submitted with or indicated on the PA form. This is to enable staff to make an accurate determination regarding the proposed plan of treatment. (sentence deleted 7/1/05)

2.1 Procedure Code Required Information (subsection deleted 7/1/05)



SECTION 3 – HOW TO FILE CLAIMS

Dental claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDCH.

3.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into the CP System, which results in faster payments and fewer claims that pend or reject. Claims can be submitted by file transfer or through the DEG. Providers submitting claims electronically must use the ASC X12N 837D 4010 A1 dental format. The payroll cut-off for electronic claims submission to MDCH is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDCH website. (Refer to the Directory Appendix for contact information.) The MDCH Electronic Submission Manual and other resources such as Companion Guides are on the website. Information on the website is updated as version changes occur at the national level and are adopted by MDCH.

3.1.A. AUTHORIZED BILLING AGENTS

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

- § Contact the MDCH Automated Billing Unit for an application packet. (Refer to the Directory Appendix for contact information.)
- § Complete and submit the forms in the application packet (an application and a participation agreement).
- § Receive an ID number.
- § Format and submit test files.
- § When test files are approved, providers receive authorization from MDCH to bill electronically.

When authorized as an electronic billing agent, any provider (including providers who bill for themselves) who wants the billing agent to submit claims on their behalf must complete and submit the Billing Agent Authorization (DCH-1343) form to MDCH. (Refer to the Directory Appendix for contact information.) This form certifies that all services the provider has rendered are in compliance with Medicaid guidelines. MDCH notifies each provider when the DCH-1343 has been processed. After notification, approved billing agents can bill electronically for themselves or for other providers that have completed the DCH-1343 indicating that the billing agent may bill on their behalf. More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ANSI X12N 835 4010A1. Authorizations remain in effect unless otherwise indicated in writing by the provider.

Complete details for the electronic billing agent authorization process, test file specifications, electronic billing information and the transaction set for dental claims can be found in the Electronic Submission Manual on the MDCH website. (Refer to the



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Directory Appendix for contact information.) Any production claims for services rendered must be billed on paper until the authorization process is complete.

Test claims are not processed for payment.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDCH. Billing agents prepare claims received from their clients, format to HIPAA compliant MDCH standards, and submit the files to MDCH for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice that reflects their individual claims. Billing agents receive a remittance advice that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

3.1.B. ELECTRONIC CLAIMS WITH ATTACHMENTS

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

3.2 PAPER CLAIMS

The ADA Version 2000 claim form must be used when submitting paper claim forms. The MDCH Optical Character Reader (OCR) scans paper claims.

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned, print or alignment problems may cause misreads, thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

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

Dot matrix printers should not be used as they result in frequent misreads by the OCR.



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Questions and/or problems with the compatibility of your equipment with MDCH scanners should be directed to the OCR Coordinator. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

3.2.A. GUIDELINES TO COMPLETE PAPER CLAIM FORMS

To assure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to do so can result in processing/payment delays or claims being returned unprocessed.

- § Dates must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 10012003). Be sure the dates are within the appropriate boxes on the form.
- § Use only black ink.
- § Do not write or print on the claim, except for the Provider Signature Certification.
- § Handwritten claims are not acceptable.
- § UPPER CASE alphabetic characters are recommended.
- § Do not use italic, script, orator, or proportional fonts.
- § 12-point type is preferred.
- § Make sure the type is even (on the same horizontal plane) and within the boxes.
- § Do not use punctuation marks (e.g., commas or periods).
- § Do not use special characters (e.g., dollar signs, decimals, or dashes).
- § Only service line data can be on a claim line. Do not squeeze comments below the service line.
- § Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- § Do not use correction fluid or correction tape, including self-correcting typewriters.
- § If a mistake is made, start over and prepare a clean claim form.
- § Do not submit photocopies.
- § Claim forms must be mailed flat, without folding, in 9" x 12" or larger envelopes. Do not fold the form.
- § Put your return address on the envelope.
- § Separate the claim form from the carbon.
- § Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut the edges of forms.
- § Keep the file copy.
- § Mail Dental claim forms separately from any other claim form type.



3.2.B. PAPER CLAIMS WITH ATTACHMENTS

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

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

3.2.C. MAILING PAPER CLAIMS

All paper claim forms and claim forms with attachments must be mailed to MDCH. (Refer to the Directory Appendix for contact information.)



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SECTION 4 – ADA COMPLETION INSTRUCTIONS

Dental Claim Form

©American Dental Association, 1999 version 2000

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services		Specialty (see backside)		3. Carrier Name																							
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT		Prior Authorization #		4. Carrier Address																							
				5. City																							
				6. State																							
				7. Zip																							
PATIENT	8. Patient Name (Last, First, Middle)			9. Address																							
	10. City			11. State																							
	12. Date of Birth (MM/DD/YYYY)		13. Patient ID #		14. Sex <input type="checkbox"/> M <input type="checkbox"/> F																						
	15. Phone Number ()			16. Zip Code																							
17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				18. Employer/School Name Address																							
SUBSCRIBER/EMPLOYEE	19. Subs./Emp. ID#/SSN#		20. Employer Name		21. Group #																						
	22. Subscriber/Employer Name (Last, First, Middle)																										
	23. Address			24. Phone Number ()																							
	25. City		26. State		27. Zip Code																						
	28. Date of Birth (MM/DD/YYYY)		29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		30. Sex <input type="checkbox"/> M <input type="checkbox"/> F																						
	31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical																										
	32. Policy #																										
	33. Other Subscriber's Name																										
34. Date of Birth (MM/DD/YYYY)			35. Sex <input type="checkbox"/> M <input type="checkbox"/> F		36. Plan/Program Name																						
37. Employer/School Name Address																											
38. Subscriber/Employer Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student																											
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. X Signed (Patient/Guardian) Date (MM/DD/YYYY)																											
40. Employer/School Name Address																											
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X Signed (Employee/subscriber) Date (MM/DD/YYYY)																											
BILLING DENTIST	42. Name of Billing Dentist or Dental Entity		43. Phone Number ()		44. Provider ID #																						
	45. Dentist Soc. Sec. or T.I.N.		46. Address		47. Dentist License #																						
	48. First visit date of current series:		49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other		50. City																						
	51. State		52. Zip Code		53. Radiographs or models enclosed? <input type="checkbox"/> Yes. How many? <input type="checkbox"/> No																						
	54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____				55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement: _____ Date of prior placement: _____																						
	56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates: _____				57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates: _____																						
	58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____																										
59. Examination and treatment plans – List teeth in order																											
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only																			
60. Identify all missing teeth with "X"						Total Fee																					
Permanent				Primary					Payment by other plan																		
1	2	3	4	5	6	7	8			9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable
61. Remarks for unusual services						Deductible																					
						Carrier %																					
						Carrier pays																					
						Patient pays																					
62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. X Signed (Treating Dentist) License # _____ Date (MM/DD/YYYY)						63. Address where treatment was performed																					
						64. City																					
						65. State																					
						66. Zip Code																					



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4.1 DENTAL CLAIM FORM COMPLETION INSTRUCTIONS

The following boxes must be completed on the ADA Version 2000 claim form unless otherwise indicated.

If no instruction is given, the boxes are optional and you do not have to enter any information.

1	Dentist's Statement of Actual Services	Mark the box titled Dentist's statement of actual services. PA requests must continue to be submitted on the MSA-1680-B form. This is a mandatory field.
2	Medicaid Claim and Prior Authorization (PA) Number	Mark the box titled Medicaid Claim. If a Box requires PA, you must list the PA Number in the area provided. This is a mandatory field.
3-7	For Provider's Use Only	
8-18	Patient/Beneficiary Information Section	
8-16	Patient Information	Fill in the boxes with the patient/beneficiary information. Providers must enter Beneficiary Name in Box 8 and the Date of Birth in Box 12. Date of Birth must be an eight-figure configuration, e.g., 03152000. Box 13 is used by the dental office to identify beneficiary/patient and is the Provider Reference Number. Boxes 8 and 12 are mandatory. The other boxes are optional.
17	Relationship to Subscriber/Employee	
18	Employer/School	
19-41	Subscriber Information Section	
19	Subs/Emp. ID#/SSN	Providers must enter the eight-digit Medicaid Beneficiary ID number of the patient identified in Box 8. Do not use the beneficiary's SSN. This is a mandatory field.
20-21	Employer Name and Group Number	
22-30	Subscriber Information	
31	Is Patient Covered by Another Plan?	This is necessary to determine Coordination of Benefits. This is a mandatory field.
32	Policy Number	Required when applicable. If "YES" in Box 31, fill in boxes 32-37. If "NO", skip boxes 32-37.
33-37	Other Subscriber's Information	



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38	Subscriber/ Employer Status	
39-41	Patient and Employee Signatures Block	
42-57	Billing Dentist Section	
42	Name of Billing Dentist of Dental Entity	Include the individual dentist's name for billing. This is a mandatory field.
43	Phone Number	
44	Provider ID Number	This is the unique provider type and provider number assigned by the Medicaid program for identification. This is a 9-digit field; the first two are the provider type and the last seven are the unique provider ID #. A space may be included between the provider type and ID number. For example, 12 7654321. This is a mandatory field.
45	Dentist Soc. Sec. or TIN	
46, 50- 52	Address, City, State, Zip Code	
47	Dentist License Number	
48	First Visit Date Current Series	
49	Place of Treatment	
53	Radiographs or Models Enclosed?	
54	Is Treatment for Orthodontics?	
55	Is Prosthesis for a Crown, Bridge or Denture, and is this Initial Placement?	
56	Is Treatment Result of Occupational Illness or Injury?	
57	Is Treatment Result of Auto Accident?	Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for Coordination Of Benefits (COB). This is a mandatory field.



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58-61	Procedure Code and Claim Information Section									
58	Diagnosis Code									
59	Examination and Treatment Plans	<p>Use the appropriate procedure codes. List the date, tooth, surface, procedure code, quantity, description and fee. Mandatory fields to be completed are date, tooth, surface, procedure code, quantity and fee.</p> <p>Where applicable, the dentist must enter the appropriate code(s) indicating the tooth surface(s) being treated.</p> <table border="1" data-bbox="743 598 1214 766"> <tr> <td>B = Buccal</td> <td>L = Lingual</td> </tr> <tr> <td>D = Distal</td> <td>M = Mesial</td> </tr> <tr> <td>F = Facial</td> <td>O = Occlusal</td> </tr> <tr> <td>I = Incisal</td> <td></td> </tr> </table> <p>Payment Information</p> <p>Each separate claim submitted must have the Total Fee box filled out even if there are multiple claims for a beneficiary.</p> <ul style="list-style-type: none"> § Do not put remarks in the Total Fee box, such as "See next page", then total all of the claims and put the entire fee on the last claim. Each claim is scanned and reimbursed separately. § The Total Fee box must include the total of all eight claim lines. This is a mandatory field. § Do not include dollar signs (\$), decimals (.), dashes (-) or spaces in the fee amount field. For example, if a procedure is \$50, then the payment information should be entered as 5000. § The Payment by other plan box must include the payment received by another third-party carrier, when applicable. § The Maximum Allowable box should be left blank. § The Deductible Box is used to submit the amount not paid by another third-party carrier when applicable. The amount should reflect the difference between the total fees and payment received from the other carrier. The program reimburses up to the programs fee screens. § The boxes, Carrier %, Carrier pays and Patient pays should be left blank. 	B = Buccal	L = Lingual	D = Distal	M = Mesial	F = Facial	O = Occlusal	I = Incisal	
B = Buccal	L = Lingual									
D = Distal	M = Mesial									
F = Facial	O = Occlusal									
I = Incisal										
60	Identify All Missing Teeth									
61	Remarks for Unusual Services	Use to indicate any information that may be helpful in determining the benefits for the treatment. Required when applicable, if the procedure performed requires documentation to be sent with claim.								
62-66	Signature Block Section									
62	Signature	A signature is required. See the General Information for Providers Chapter of this manual for the provider certification requirements and acceptable signatures for the claim form.								
63-66	Address	Enter address where treatment was performed.								



SECTION 5 – SPECIAL BILLING INSTRUCTIONS [CHANGES MADE 7/1/05]

5.1 SUPERNUMERARY TEETH

Providers must bill D7999 (unspecified oral surgery by report code) for supernumerary teeth. This code can only be used once per claim. The extraction procedure performed (STI, PBI, CBI) and the location in the mouth must be included in the Remarks field. If there is more than one supernumerary tooth, the quantity extracted must also be included.

The total fee billed should reflect the number of extractions completed. The claim will pend for review. Payment will be based on the type of extraction performed.

5.2 LOSS OR CHANGE IN ELIGIBILITY [NEW SUBSECTION ADDED 7/1/05]

Providers can only bill for root canal therapy, complete and partial dentures, and laboratory-processed crowns if loss or change in eligibility occurs. Services must have been started prior to the loss of eligibility.

- § Bill with Not Otherwise Classified (NOC) procedure code D5899
- § Include a copy of the lab bill for complete or partial dentures, and laboratory-processed crowns
- § Provide an explanation in the Remarks section of the claim
- § For complete or partial dentures and laboratory-processed crowns, the date of service on the claim should be the date of the initial impression
- § For root canal therapy, the date of service should be the first treatment appointment

5.3 INCOMPLETE ROOT CANAL [NEW SUBSECTION ADDED 7/1/05]

For an incomplete root canal:

- § Providers must bill the Not Otherwise Classified (NOC) procedure code D3999
- § Provide an explanation in the Remarks section of the claim
- § Date of service should be the first treatment appointment



SECTION 6 – REPLACEMENT CLAIMS

6.1 GENERAL INFORMATION [CHANGE MADE 10/1/05]

Replacement claims must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDCH has made payment. Reasons claims may need to be replaced:

- § To return an overpayment (report "returning money" in Remarks section);
- § To correct information submitted on the original claim such as changing the date of service, tooth number or incorrect charges;
- § To correct an incorrect provider ID number or beneficiary ID number (refer to the void/cancel process below); (per bulletin MSA 05-43 issued 9/1/05)
- § To report payment from another source after MDCH paid the claim (report "returning money" in Remarks section); and/or
- § To correct information that the scanner may have misread (state reason in Remarks section).

If all service lines on a claim were rejected, the services must be resubmitted as a new claim, not a replacement claim.

6.2 CLAIM REPLACEMENT AND VOID/CANCEL CLAIMS [RENAMED AND CHANGES MADE 10/1/05]

Providers may submit a replacement claim using the ADA paper dental claim form or electronically using the 837 claim format.

Providers using the paper dental claim form to submit a replacement claim must submit a new claim. All service lines, including correctly paid lines, must be reported on the replacement claim. All money paid on the first claim will be debited and the new payment will be based on the information reported on the replacement claim. All instructions for claim completion apply for the replacement claim.

In field 61, "Remarks for Unusual Services" on the paper claim form, providers must write the word CRN with a colon, then include the 10-digit Claim Reference Number (CRN). Any additional comments may be entered after this information.

Instructions for submitting an electronic replacement claim are contained in the MDCH 837D Companion Guide available on the MDCH website. (Refer to the Directory Appendix for website information.)

Providers using the paper dental claim form to submit a void/cancel claim must submit a new claim. Only one service line needs to be completed with zero dollars entered in the charges or money field. All money paid on the first claim line will be deleted. Upon notification through the Remittance Advice that the money has been deleted from the Medicaid system, a new claim with the correct provider ID and/or beneficiary ID may be submitted.

For submission of paper replacement and void/cancel claims, refer to the Directory Appendix for contact information.

(per bulletin MSA 05-43, issued 9/1/05)



6.3 PAYMENT REFUNDS

Return of overpayments made by MDCH, due to either payment from a third party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to inactive providers or monies being returned to MDCH due to settlements or lawsuits. In these situations, checks must:

- § be made payable to the State of Michigan in the amount of the refund
- § include the provider EIN (tax) number
- § be sent to MDCH Cashier's Unit. (Refer to the Directory Appendix for contact information.)

Do not submit a replacement claim and manually send a refund to the Cashier's Unit as this results in an incorrect refund amount.



SECTION 7 – CHANGES IN ELIGIBILITY AND ENROLLMENT (FFS/CSHCS)

7.1 GENERAL INFORMATION

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

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

7.2 BILLING REQUIREMENTS

MDCH policy directs providers to bill the date of delivery for dentures and laboratory-processed crowns. However, when a beneficiary has a change in eligibility status and services have been started for root canal therapy, dentures and laboratory-processed crowns, the provider has 30 days from the loss or change in eligibility status to complete the services. The date of service on the claim form should be the date of the initial impression for dentures and laboratory-processed crowns.



SECTION 8 – REMITTANCE ADVICE

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

8.1 PAYMENTS/CLAIM STATUS

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

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

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider ID number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

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

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

8.2 ELECTRONIC REMITTANCE ADVICE

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

The electronic RA has many advantages:

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



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

For more information regarding the 835 and 277U transactions issued by the MDCH, refer to the MDCH Companion Documents on the MDCH website. For general information about the 835 and 277U, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.3 PAPER REMITTANCE ADVICE

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

The following information is supplied on the paper RA Header:

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

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



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Field Name	Explanation
Claim Header	<p>Patient ID Number: Prints the beneficiary's Medicaid ID number that the provider entered on the claim.</p> <p>Claim Reference Number (CRN): A 10-digit CRN is assigned to each claim. If the claim has more than one service line, the same CRN is assigned to each line. The first four digits are the Julian Date the claim was received by MDCH. The fifth through tenth digits are the sequential claim number assigned by the MDCH.</p> <p>Example: In CRN 3223112345, 3 is the year 2003, 223 is the Julian day of the year (August 11), and 112345 is the sequence number. The combination of Julian day and sequence makes a unique number that is assigned to each claim. When asking about a particular claim, the provider must refer to the CRN and Pay Date.</p> <p>The 10-digit CRN is following by a two-character input ID (3223223445-XX). If a service bureau submitted the claim, this is the service bureau ID. If the provider submitted a paper claim, this is a scanner identifier.</p>
Line No.	This identifies the line number where the information was entered on the claim.
Invoice Date	This identifies the date the provider entered on the claim or, if left blank, the date the claim was processed by the system.
Service Date	This identifies the service date entered on the claim line (admit date for inpatient service).
Procedure Code	This identifies the procedure code or revenue code entered on the service line.
Qty	This identifies the quantity entered on the service line. If the MDCH changed your quantity, an informational edit appears in the Explanation Code column.
Amount Billed	This identifies the charge for the entire claim.
Amount Approved	<p>This identifies the amount the MDCH approved for the service line (amount approved for DRG represents the entire claim and it is not approved by claim line). Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from MDCH.</p> <p>For example, when other resources made a payment greater than MDCH's usual payment.</p>
Claim Adjustment Reason Code	Claim adjustment reason codes communicate why a claim or service line was paid differently than was billed. If there is no adjustment to a claim line, then there is no adjustment reason code.



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Field Name	Explanation
Claim Remark Code	Claim remark codes relay service line specific information that cannot be communicated with a reason code.
Invoice Total	Totals for the Amount Billed and the Amount Approved print here.
Insurance Information	If Medicaid beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g., vision, medical) print below the last service line information.
History Editing	Certain edits compare the information on the claim to previously paid claims. In some cases, information about the previous claim prints on the RA. This information prints directly under the service line to which it relates.
Page Total	This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two RA pages, the page total includes only the paid lines printed on each RA page.

8.4 GROSS ADJUSTMENTS

Gross adjustments are initiated by the MDCH. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on the RA.

The paper RA indicates gross adjustments have been made by:

- § **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used. Code definitions can be found in the 835 Implementation Guide.
- § **Gross Adjustment Code:** This is the MDCH gross adjustment code that corresponds to the gross adjustment description.

Code	Name	Explanation
GACR	Gross Adjustment Credit	This appears when the provider owes MDCH money. The gross amount is subtracted from the provider's approved claims on the current payroll.
GADB	Gross Adjustment Debit	This appears when MDCH owes the provider money. The gross adjustment amount is added to the provider's approved claims on the current payroll.



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Code	Name	Explanation
GAIR	Gross Adjustment Internal Revenue	This appears when the provider has returned money to MDCH by check instead of submitting a replacement claim. It is subtracted from the provider's YTD (Year To Date) Payment Total shown on the summary page of the RA.

8.5 REMITTANCE ADVICE SUMMARY PAGE

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

Field Name	Explanation
This Payroll Status	The total number of claims and the dollar amount for the current payroll. This includes new claims plus pended claims from previous payrolls that were paid, rejected, or pended on the current payroll.
Approved	Number of claims from this payroll with a payment approved for every service line. The dollar amount is the total approved for payment.
Pends	Number of claims from this payroll that are pending. The dollar amount is the total charges billed.
Rejected	Number of claims from this payroll with a rejection for every service line. The dollar amount is the total charges billed.
App'd/Rejected	Number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total approved. The amount next to Rejected Claim Lines is the total charge billed.
Total Pends in System	Number of new and unresolved pended claims in the system and related total charges.
Previous YTD (Year to Date) Payment Total	The total amount paid for the calendar year before any additions or subtractions for this payroll.
Payment Amount Due This Payroll to Provider	Payment Amount Approved, plus any balance due to the provider, minus any balance owed by the provider to MDCH.



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Field Name	Explanation
Payment Made This Payroll	The amount of the check or EFT issued for this payroll.
New YTD Payment Total This Payroll	Total payment for the calendar year, including payments made on this payroll.
Balance Owed or Balance Due	<p>One or more of the following messages prints if there is a balance owed or a balance due.</p> <ul style="list-style-type: none"> § Balance Due to Provider by MDCH: This appears if the payment amount approved is less than \$5.00 or a State account is exhausted. § Balance Owed by provider to MDCH: This appears when money is owed to MDCH, but you do not have sufficient approved claims from a particular State account (e.g., CC or ABW) to deduct what is owed. § Previous Payment Approved, Not Paid: This appears if a balance is due from MDCH on the previous payroll. § Previous Payment owed by Provider to MDCH: This appears when a balance is due from you on a previous payroll.
Pay Source Summary	Identifies the dollar amounts paid from the designated State accounts.

8.6 PENDED AND REJECTED CLAIMS

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

- § **Rejections:** If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definitions of the codes to determine the reason for the rejection.
- § **Pends:** If any service line pends for manual review, PEND prints in the Claim Adjustment Reason/Remark column of the RA. These pended claims do not print again on the RA until the claim:
 - Ø Is paid or rejected;
 - Ø Is pended again for another reason; or
 - Ø Has pended for 60 days or longer.

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



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



SECTION 9 – JULIAN CALENDAR

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

For leap year, one day must be added to number of days after February 28. The next three leap years are 2008, 2012, and 2016.

Example: claim reference # 3351203770-59
 3 = year of 2003
 351 = Julian date for December 17
 203770 = consecutive # of invoice
 59 = internal processing