Billing & Reimbursement

FY 2017

BCCCN P
Breast and Cervical Cancer
Control Navigation Program

COLORECTAL CANCER
Preventable. Treatable. Beatable!

WISEWOMAN
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History and Overview

BCCCNP, WW and Colorectal services are coordinated through 16 Local Coordinating Agencies (LCA). These agencies partner with physicians, hospitals, and other health care organizations in their communities to provide all screening and any necessary follow-up services. LCAs are required to provide or arrange for basic screening services. This includes clinical breast exams (CBE), screening mammograms, pelvic exams, Pap smears, patient education/navigation, FITs, and screening colonoscopies.

To be enrolled, women (or men for the Colorectal Program) must meet the following criteria:
- Residency Requirement
- Age Requirement
- Income Level Requirement
- Insurance Requirement

Residency Requirement: (must be a Michigan Resident)
- US Citizen and Michigan Resident (as determined by verifiable current address (E.g. driver’s license, voter ID, Passport)
- Non US Citizen but Michigan Resident: Enroll in BCCCNP (Not eligible for Medicaid or Insurance Marketplace unless non-citizen has been a resident for at least 5 years)
- EXCEPTIONS for Residency Status:
  - Migrant workers
  - Women living near the border of a neighboring state (Indiana, Ohio, Wisconsin, Minnesota) who plan to receive screening and/or diagnostic services in Michigan
  - Women who opt not to purchase insurance secondary to religious objections

Age Requirement:

BCCCNP
1. Age 40 – 64 are eligible to receive:
   - Breast and/or cervical cancer screening, and/or diagnostic services
2. Age 21-39:
   - Must be referred to BCCCNP from a Family Planning (FP) program provider.
   - ONLY eligible to receive cervical diagnostic services for follow-up of a cervical abnormality.
3. Age 25-39:
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- Must be referred to BCCCNP from a Family Planning (FP) program provider.
- ONLY eligible to receive breast diagnostic services for follow-up of an abnormal clinical breast exam. Refer to BCCCNP Medical Protocol for Enrolling Women Ages 25-39 with Abnormal CBE Results.

Income Level Requirement:
- < 138% Federal Poverty Level (FPL) and UNINSURED
- > 138% but ≤ 250% and UNINSURED
- > 138% but ≤ 250% and UNDERINSURED
- > 250%: Ineligible for BCCCNP – Inform woman that she can enroll in a health plan during open enrollment for the Insurance Marketplace. Refer to a certified health insurance enrollment counselor at ENROLL MICHIGAN OR www.michigan.gov/mibridges.

NOTE: Women who are enrolled in a managed care program, a health maintenance organization, or Medicare Part B are not eligible for the BCCCNP.

The following link is to Poverty Guidelines, Research, and Measurement http://aspe.hhs.gov/poverty/.

### 2016 Poverty Guidelines

<table>
<thead>
<tr>
<th>Size of Family Unit</th>
<th>Poverty Guideline</th>
<th>250% of Poverty</th>
<th>138% of Poverty</th>
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<tr>
<td>1</td>
<td>$11,880.00</td>
<td>$29,700.00</td>
<td>$16,394.40</td>
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<td>$16,020.00</td>
<td>$40,050.00</td>
<td>$22,107.60</td>
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<td>$50,400.00</td>
<td>$27,820.80</td>
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<td>4</td>
<td>$24,300.00</td>
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<td>$33,534.00</td>
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<td>$28,440.00</td>
<td>$71,100.00</td>
<td>$39,247.20</td>
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<td>6</td>
<td>$32,580.00</td>
<td>$81,450.00</td>
<td>$44,960.40</td>
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<td>7</td>
<td>$36,730.00</td>
<td>$91,825.00</td>
<td>$50,687.40</td>
</tr>
<tr>
<td>8</td>
<td>$40,890.00</td>
<td>$102,225.00</td>
<td>$56,428.20</td>
</tr>
<tr>
<td>Each Additional Member (Beyond 8)</td>
<td>$4,160.00</td>
<td>$10,400.00</td>
<td>$5,740.80</td>
</tr>
</tbody>
</table>
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Services Available

**BCCCNP - Screening:** women ages 40-64 can receive screening services such as:
- Clinical Breast Exams (NOT considered a cancer screening service)
- Pap smears
- Pelvic exams
- Screening mammograms

**BCCCNP Diagnostic:**
If a breast and/or cervical abnormality are identified from the screening test/exam, the woman will be referred to community providers for follow-up. Over 70 diagnostic services are provided free of cost through the BCCCNP. Some of these include:
- Diagnostic mammograms
- Ultrasounds
- Breast Biopsy
- Colposcopy services
- Selected anesthesia services (19120 & 19125)

**MCRCEDP - Screening:** men and women, ages 50-64 can receive screening services such as:
- Fecal Immunochemical Test (FIT)
- Colonoscopy

**MCRCEDP - Diagnostic:** men and women, ages 50-64:
- Double-contrast barium enema (DCBE)
- Sigmoidoscopy

Cancer Treatment:
In the event of a diagnosis of breast and/or cervical cancer through the BCCCNP, a woman may be eligible for Medicaid coverage. If eligible, Medicaid will pay for all of her medical expenses for as long as she is being treated for the cancer.

Once treatment is no longer needed, the woman is then potentially eligible (once again, based upon age and income) for continued annual screening services through the BCCCN Program.

A BCCCNP woman remains eligible for Medicaid until:
Her health professional deems the woman is free from cancer and will not require continued cancer therapy, OR

She no longer meets the eligibility criteria for this program:
- Obtained creditable insurance coverage, or
- Reached the age of 65 and has Medicare Part B.
Illegal aliens:

- **Note:** Women (and men for the colorectal program), who are illegal aliens, although eligible for services, cannot receive Medicaid coverage. Federal law limits Medicaid coverage to citizens and legal aliens.

**Goal:** Provide timely/appropriate, cost effective, care to eligible Michigan clients:

- Timely/appropriate care
  - Care provided according to Medical Protocol(s) and guidelines
- Cost Effective Care
  - Provision of care within budget constraints: “Balancing quality of care delivery with cost”
- Evaluation of Data Quality
  - Documentation of care according to CDC requirements

**Figure 1 – Goal diagram**
Provider Information

CONTRACTS with Local Coordinating Agencies (LCA):

- Sign a contract or letter of agreement with the LCA agreeing to provide screening and/or diagnostic services for clients according to program requirements and rates.
- Send the following information to the LCA to enroll as a provider in the Program:
  - Provider’s Federal Tax ID Number and NPI Number
  - Provider’s Physical Address
  - Billing (Cash Application and/or Posting) Contact Info:
    - Name
    - Phone #
    - Fax #
    - Email address
- Any change in provider or billing information must be communicated to the LCA as soon as possible to avoid delays in provider reimbursement.

NOTE: Providers cannot be paid until enrollment information is received by the LCA and forwarded to the State.

Providers will not be entered until the information has been approved by the LCA and contracts are in place.
Client Enrollment

- A client can fill out enrollment paperwork at either a provider’s office or an LCA.
- If the client is enrolled at a provider’s office, they must fax the paperwork to the LCA.
  - The Client Enrollment form must be faxed or mailed to the LCA within 72 HOURS TO AVOID DELAY IN REIMBURSEMENT.
- The paperwork will then have to be entered into the MBCIS database.
- Failure to send enrollment paperwork to the LCA can cause your claim(s) to be rejected.
  - Your claim(s) may reach MDHHS before the client has been enrolled (data entry) into the program resulting in a rejection.

Figure 2 – Client Enrollment
Client Services

- Client screening service(s) can be performed at either the provider’s office or an LCA.
- Screening paperwork is then sent to the LCA - if services were performed at a provider’s office.
- This information must be data entered into the MBCIS database and authorized in order for the service(s) to be paid.

Figure 3 – Client Services

Client goes to LCA and Provider for screening service

Local Agency (screening services)

Provider (screening services)

Screening Paperwork

Screening Service information entered into database

BCCCP Database

MBCIS Database
Providers/LCAs will submit their claims to MDHHS for processing.
- Paper claims are mailed to Lansing and electronic claims are submitted via Data Exchange Gateway (DEG) or one of its affiliated clearinghouses.
- MDHHS will adjudicate claims (payment or rejection) nightly.

Figure 4 – Claim Submission
Every evening, MDHHS receives a claim file to be adjudicated.
Weekly, a file is sent to MDHHS Accounting with a list of claims to be processed for payment.
Weekly, provider checks or EFTs (Electronic Funds Transfers) are released.
Weekly, payment details are FAXed to the provider by MDHHS staff.

Figure 5 – Adjudication Process

Contact Tory Doney (DoneyT@michigan.gov) to be added as a contact person for your facility.
Claim Number:
Each claim number consists of 14 digits:
Example: 01 01242016 3 026
  • 01 (first 2 digits) = Program
    o 01 = BCCCNP
    o 02 = WISEWOMAN
    o 03 = Colorectal
    o 04 = Patient Navigation
  • 01242016 (next 8 digits) = Received Date
    o 01/24/2016
  • 3 (next digit) = Type of Claim
    o 1 = Paper UB
    o 2 = Paper HCFA
    o 3 = Electronic UB
    o 4 = Electronic HCFA
  • 026 (last 3 digits) = Sequence #

Non-reimbursable Procedures:
CDC does not allow reimbursement of the following procedures:
• CAD (Computer Assisted Device)
• Tomosynthesis

Providing Screening and/or Diagnostic Services:
• Provide the appropriate screening and/or diagnostic services to the client or refer for appropriate services.
• Review the screening and/or diagnostic services results.
  – Contact the LCA to arrange for further follow-up care if needed.
• Send screening results and diagnostic service information to the LCA as soon as services are completed.

The LCA must receive this information prior to approving payment for services rendered.

Billing:
• Providers must bill on an HCFA 1500 or UB-04 form at their USUAL AND CUSTOMARY RATE, not the Program reimbursement rate.

• Only CPT codes listed on the current fiscal year reimbursement rate schedules will be reimbursed.

• An approved ICD-10 code is required.
  o Only the PRIMARY diagnosis codes is utilized by MDHHS programming
• An approved Revenue codes (UB-04) is required.
  o All Revenue codes must be 4 digits

• An approved Place of Services code (HCFA-1500) is required.

All other codes will be rejected.

• Providers **cannot** bill clients for any program-approved procedures.
• Providers **cannot** balance-bill the client.

Claims will be **PAID** by the Program if:

• All required claim information for the client is submitted on either the HCFA 1500 or UB-04 form.
  
  **AND**

• The claim contains Program-approved CPT, ICD-10, Revenue and Place of Service codes.
  
  **AND**

• All screening exam results and/or diagnostic service information has been sent to the LCA to be entered into the MBCIS data system

**Figure 7 – Data entry and Billing Authorization on file**

Data Entry & Billing Authorization on file:

Claim is received at MDHHS → Claim is sent through MBCIS database to check validity of ICD-10/CPT codes and AUTHORIZATION (Auth) → $$$ is processed and payment is issued to the provider → Claim has been fully adjudicated

If Auth IS present – the claim is adjudicated

**Why would my claims be PENDED?**

• Provider not enrolled in MBCIS database.
  
  **OR**

• Client screening and/or diagnostic data not sent to the LCA.
The LCA will approve payment of the claim once data is received.
Claims will be rejected after 30 days if data is not received during that time period.
Claims will then need to be resubmitted for payment.

Figure 8 – Data Entry and Billing No Authorization on file

Data Entry & Billing No Authorization on file:

Claim is received at MDHHS

Claim is sent through MBCIS database to check validity of ICD-10/CPT codes and AUTHORIZATION (Auth)

If Auth IS NOT present – the claim continues on a nightly cycle to check for Authorization

Claim rejects – “39” - and details are sent to the provider
After 30 days – the claim is REJECTED

Why would my claim be REJECTED?

• Information needed for processing the claim is missing from HCFA1500 / UB-04. OR
• Claim does not contain Program-approved CPT, ICD-10, Revenue codes or Place of Service codes. OR
• Client is not enrolled in the Program.

Who should I contact if I have a question about my claim?

• All inquiries related to claims processing should be directed to the Claims Hotline at 866-930-6324 or FAXED to 517-335-8752.
• Inquiries related to patient care or results of clinical services should be directed to the LCA.

What information is required to check the status of a claim?

• Client MBCIS # / Social Security Number (SSN)
• Procedure code (CPT code)
• Date of Service (DOS)
• Provider Federal ID
• CLAIMS WILL NOT BE STATUSED WITHOUT THIS INFORMATION!!
Health Insurance Portability and Accountability Act (HIPAA):
- We receive a very large number of claims that the envelopes are barely sealed or not sealed at all. Please ensure the security of your mailing envelopes.
- **DO NOT** email client sensitive data (SS#, Name, DOB)
- **DO NOT** include client sensitive data (SS#, Name, DOB) on your Fax Cover Sheet.
  - Please be sure to use a Fax Cover Sheet when faxing claims to MDHHS.
    - Note: Claims are NOT accepted via Fax. Only claim status is available via Fax.
- Before sending claims to MDHHS, ask yourself this question - Is this how I would like my medical claims/records handled/mailed?

Electronic Billing (EDI):

In accordance with HIPAA standards, **effective January 1, 2012**, providers must submit electronic 837P and 837I claims files using the X12 version 5010.

**NOTE:** Paper claims WILL be accepted. Please click [here](#) for paper submission details and guidelines.

Payer ID: **D00111**
DEG Mailbox: **DCHEDI**
Submitter ID: "**00_ _**" (example: DCH00AB)
Application ID (File Name): **5495**

Loop 1000B, Segment NM103 – ‘BCCCP’
Loop 1000A, Segment NM109 - ‘00_ _’ (example: DCH00AB)
Loop 1000B, Segment NM109 – ‘D00111’

**Clearinghouse Submitter IDs:**
006i - All Scripts / Payer Path
004V - Automated Business Systems
0070 – ClaimRemedi
00DL – Emdeon
00P1 - Gateway EDI
00NF - Netwerkes
0049 - PMG - The Physician’s Billing Specialists
00VV - QUADAX
00YB - Relay Health / McKesson
00ZA - Tri-Med Group
0099 - Western MI Business Services
005U - XACTIMED / Med Assets

**Common Payer IDs:**
- Relay Health: Professional CPID – 6109
- Relay Health: Institutional CPID – 1624
- Emdeon: Professional – SKMI1
- Emdeon: Institutional – 12K38

**999 files will be generated:**
- "A" = Accepted
- "E" = Accepted w/ Errors - no need to resubmit
- "R" = Rejected - file must be corrected and resubmitted
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835RA files will be generated:
- File Name: 5469
- Sender: DCHBULL
- Availability: Weekly on Thursday mornings

** If you have the capability to receive 835RA files, but are currently not doing so, please contact Tory Doney.

**Hold codes or 835RA Adjustment Codes**

A hold code (or 835RA Adjustment Codes) is an explanation for how the claim was processed.

1) I9 or “167” – ICD-10 code not in contract
   - Claim will **reject**

   **Problem:**
   - ICD-10 code used is not a program-approved code.

   **Solution:**
   - Re-submit claim with program-approved ICD-10 code.

2) IC or “45” – Insurance Payment
   - Claim will **reject**

   **Problem:**
   - Primary Insurance paid more than the BCCCNP rate.

   **Solution:**
   - Claim is considered paid in full and the client can not be balance billed the remainder of the charge.

3) IP or “45” – Insurance Partial Payment
   - Claim will **pay**

   **Problem:**
   - Primary Insurance paid less than the BCCCNP rate.

   **Solution:**
   - BCCCNP will pay the difference between the insurance payment and the BCCCNP approved rate. The client can not be balanced billed the remainder of the charge.
4) **JL or “16” – Revenue code not in contract**  
Claim will reject

**Problem:**  
Revenue code billed is not a program-approved code.

**Solution:**  
Re-submit claim with program-approved revenue code.

5) **JM or “96” – CPT code not in contract**  
Claim will reject

**Problem:**  
CPT/HCPCS code billed is not a program-approved code.

**Solution:**  
Re-submit claim with program-approved CPT/HCPCS code.

6) **N5 or “29” - Prior Fiscal Year**  
Claim will reject

**Problem:**  
Claim submitted with a Date of Service in a prior fiscal year.

**Solution:**  
N/A – Claims will not be paid after the year-end deadlines.

**Fiscal year runs October 1st 20XX to September 30th 20XX**

7) **N8 - Provider not enrolled**  
Claim will not be entered and will be returned to the provider.

**Problem:**  
Provider not enrolled in the program.

**Solution:**  
The provider needs to contact the LCA in their area about becoming a BCCCNP Provider.  
- OR visit [www.michigancancer.org/BCCCP](http://www.michigancancer.org/BCCCP)  
- If you are an approved provider, contract the LCA you have a contract with
8) N9 or “B20” - Service Partially/Fully done by another Provider
   Claim will reject

   **Problem:**
   Two providers have billed for the same CPT on the same DOS for the same client.

   **Solution:**
   Contact the Claims Hotline (866-930-6324) for additional help.

9) ND or “18” – Duplicate claim
   Claim will reject

   **Problem:**
   This is a duplicate claim that has already been adjudicated under a different claim number.

   **Solution:**
   Call the Claims Hotline to request a manual over-ride. You cannot simply keep rebilling because the system will view the historical line as paid and keep rejecting your claim.

10) NE or “05” – Place of Service not covered
    Claim will reject

    **Problem:**
    BCCCNP does not cover the Place of Service code used

    **Solution:**
    Re-submit claim with a program-approved POS code.

11) PB, AR, PS or “39” – Authorization required
    Claim will reject after 30 days

    **Problem:**
    The service has not been authorized by the LCA

    **Solution:**
    Service information needs to be sent to the LCA immediately; and/or the service information needs to be entered into the MBCIS database. Follow up with the LCA.

    **If the service is not entered and authorized with in 30 days of the claim getting into the system, it will then reject.**
Figure 9 – How claims are authorized

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Exam Type</th>
<th>Rpt Service Date</th>
<th>Facility Name</th>
<th>Funding Source</th>
<th>Last Exp Dt</th>
<th>Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>Screening</td>
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<td>Sparrow Health System</td>
<td>State</td>
<td>10-25-2006</td>
<td>Y</td>
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<td>Ultrasound</td>
<td>Breast</td>
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<td>Federal-BCOP</td>
<td>10-11-2006</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Cervical</td>
<td>Pelvic Exam</td>
<td>N 10-04-2006</td>
<td>Federal-BCOP</td>
<td>10-11-2006</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

12) UN, UT or “222” – Number of Units Mismatch
Claim will reject

Problem:
(1) The provider has billed for multiple units and only 1 unit has been authorized by the LCA.
(2) The provider billed multiple services with the same CPT code and date of service each on a separate line instead of all on 1 line with the number of units indicated on the claim form.

Solution:
(1) Contact the LCA, as there will need to be additional data entry performed.
(2) Re-bill utilizing units

Figure 10 – Example of Unit Billing
13) **BC, RC, WC or PN or “31” – Client is not enrolled**
Claim will [reject]

**Problem:**
(1) Client is not enrolled;
OR
(2) Provider is billing for a BCCCNP service using a WW or MCRCEDP ICD-10 code or vice versa.

**Solution:**
(1) Call the LCA you have a contract with and verify whether or not the client is in the Program;
(2) Re-bill the claim with the appropriate ICD-10 code.

14) **XA or “45” – Denied claim paid**
Claim will be [paid]

**Problem:**
Claim was denied in error

**Solution:**
Payment will be manually processed by MDHHS employees

15) **XB or “B10” – Payment error**
Payment will be [taken back] or provider will need to [refund] the Program

**Problem:**
Claim paid in error

**Solution:**
(1) Tack back/recovery has been requested for the billing service and will appear as a negative amount on future remittance
(2) Provider can send a check back directly to the State of Michigan

**Send check to:**
MDHHS - BCCCNP
DCH Accounting Division
PO Box 30437
Lansing, MI 48909

**Make check payable to:** [STATE OF MICHIGAN]
BCCCNP and County Health Plan (CHP):
BCCCNP and the various CHPs of Michigan serve many of the same women. BCCCNP is the primary for CHP for reimbursement of services provided by both BCCCNP and CHP. If a provider receives payment for a service that can be paid by BCCCNP – please refund the County Health Plan (CHP) and bill the services to BCCCNP.

Common Billing Issues:
1. Client ID – should be the clients social security number
   - Client ID field is empty
   - Client ID is BCCCP
   - Client ID is 00000
   - Client ID is 5555
   - Client ID is 999-99-9999
   - Client ID is 111-11-1111
   - Client ID is 123-45-6789
   - Client ID is HPMS#
   - Client ID does not match what is entered in MBCIS database
2. CPT/HCPCS Codes – not reimbursed by the Program
   - 77052/77051 (CADs)
   - Drugs and other supplies (bandages) used during surgical procedures
3. Client not on file
   - Claims billed prior to client enrollment at LCA
   - Claims billed for clients that are inactive in our system
4. Not Unit Billing
5. Claim for DOS in prior fiscal year
6. Claims being addressed incorrectly
   - DO NOT address the claims to NATIONWIDE HEALTH PLANS
   - DO NOT address the claims to HEALTH ADVANTAGE
   - DO NOT address the claims to MEDICAID TITLE XV
   - DO NOT address the claims to KARMANOS
   - DO NOT address the claims to HURON HEALTH DEPARTMENT

Claims must be addressed to MDHHS CLAIMS. Any other address may be sent back as unidentifiable – as all mail is processed through the State of Michigan mailroom and not individually by the Programs.
Figure 11 — Example of a claim being sent to Nationwide

- Fiscal Year End Information
  - Fiscal year ends September 30th of every year (FY'XX runs 10/1/20XX to 9/30/20XX.)
  - Original fiscal year claims MUST be received by MDHHS by December 31st of any fiscal year.
  - For example, fiscal year 15 (FY15) ends on September 30, 2015 and fiscal year 16 (FY16) starts on October 01, 2015.
  - All original claims for fiscal year FY15 must be received no later than December 31, 2015.
  - Any original fiscal year 15 claim received by MDHHS after 12/31/2015 WILL be rejected with N5 – prior fiscal year.
  - Original claims include claims waiting for EOBs.
  - Corrections for fiscal year 15 must be received by MDHHS by close of business middle of March each year.

End of year dates change annually.

Frequently Asked Questions

What happens if a client does not have a SSN?
Contact the LCA with whom you have a contract to see if one is on file OR call the Claim Hotline – 866-930-6324. State staff will assign a number to be used for billing purposes.
Contact Information

Claim Hotline:
866-930-6324 – phone - This line will be answered by MDHHS staff
517-335-8752 – fax

Physical Address
MDHHS
109 Michigan Ave
WSB – 5th Floor
Lansing, MI 48913

Tory Doney
Department Analyst/Lay Navigator
DoneyT@michigan.gov
517-335-8854 – phone

Sam Burke
Program Technical Analyst/Lay Navigator
BurkeS5@michigan.gov
517-241-6913 – phone

BCCCNP Documents

www.michigancancer.org/BCCCP

>> Billing & Reimbursement

- Rate Schedules
- ICD-10 Codes
- Revenue Codes
- Place of Service (POS) codes
- Hold Codes – 835RA Adjustment Codes
- Billing & Reimbursement Guide
- Billing – Paper & Electronic Claim Submission
- Procedure Code Reference Chart

WISEWOMAN Documents

http://www.michigancancer.org/BCCCP/WiseWomanProgram/

>> Program Management
>> Financial Resources

- Rate Schedule
- ICD-10 Codes
- Hold Codes – 835RA Adjustment Codes
2017 Billing Manual

- Revenue Codes
- Place of Service (POS) codes
- Procedure Code Reference Chart

Colorectal Documents

[http://www.michigancancer.org/Colorectal/](http://www.michigancancer.org/Colorectal/)

>> Billing & Reimbursement

- Rate Schedule
- ICD-10 Codes
- Hold Codes – 835RA Adjustment Codes
- Revenue Codes
- Place of Service (POS) codes
- Procedure Code Reference Chart
- Billing and Reimbursement Policy