Billing & Reimbursement

2015

BCCCP
Breast and Cervical Cancer Control Program

Colorectal Cancer
Preventable. Treatable. Beatable!

WISEWOMAN
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History and Overview

BCCCP, WW and Colorectal services are coordinated through 20 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, FOBTs, 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 BCCCP (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:

BCCCP
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 BCCCP 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:
   - Must be referred to BCCCP from a Family Planning (FP) program provider.
2015 Billing Manual

- ONLY eligible to receive breast diagnostic services for follow-up of an abnormal clinical breast exam. Refer to *BCCCP Medical Protocol for Enrolling Women Ages 25-39 with Abnormal CBE Results.*

**MCRCEDP**

1. Age 50 – 64 are eligible to receive:
   - Average Risk: FOBT
   - Increased Risk: Screening colonoscopy

**Income Level Requirement:**
- ≤ 138% Federal Poverty Level (FPL) and UNINSURED
- > 138% but ≤ 250% and UNINSURED
- > 138% but ≤ 250% and UNDERINSURED
- > 250%: Ineligible for BCCCP – 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](http://enrollemichigan.org) OR [www.michigan.gov/mibridges](http://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 BCCCP.

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

**2015 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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<td>$11,770.00</td>
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<td>8</td>
<td>$40,890.00</td>
<td>$102,225.00</td>
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<td>Each Additional Member (Beyond 8)</td>
<td>$4,160.00</td>
<td>$10,400.00</td>
<td>$5,740.80</td>
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</tbody>
</table>
Services Available

BCCCP - Screening: women ages 40-64 can receive screening services such as:

- Clinical Breast Exams
- Pap smears
- Pelvic exams
- Screening mammograms

BCCCP 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 BCCCP. 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:

- Annual Fecal Occult Blood Test (FOBT)
- Screening 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 BCCCP, 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 BCCC Program.

A BCCCP 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, who are illegal aliens, although eligible for BCCCP 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.
  o 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.
  o Your claim(s) may reach MDCH 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)

Screening Paperwork

Provider (screening services)

Screening Service information entered into database

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

Figure 4 – Claim Submission
Adjudication Process

- Every evening, MDCH receives a claim file to be adjudicated.
- Weekly, a file is sent to MDCH 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 MDCH staff.

Figure 5 – Adjudication Process
Claim Number:
Each claim number consists of 14 digits:
Example: 01 01242012 3 026
  • 01 (first 2 digits) = Program
    o 01 = BCCCP
    o 02 = WISEWOMAN
    o 03 = Colorectal
  • 01242012 (next 8 digits) = Received Date
    o 01/24/2012
  • 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)

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-9 code is required.
    o Only the PRIMARY diagnosis codes is utilized by MDCH
      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-9, 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 MDCH → Claim is sent through MBCIS database to check validity of ICD-9/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.
Why would my claim be REJECTed?

- Information needed for processing the claim is missing from HCFA1500 / UB-04.
- Claim does not contain Program-approved CPT, ICD-9, Revenue codes or Place of Service codes.
- 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 MDCH.

- Note: Claims are NOT accepted via Fax. Only claim status is available via Fax.

- Before sending claims to MDCH, 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’

<table>
<thead>
<tr>
<th>Clearinghouse Submitter IDs</th>
<th>Common Payer IDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0061 - All Scripts / Payer Path</td>
<td>Relay Health: Professional CPID – 6109</td>
</tr>
<tr>
<td>004V - Automated Business Systems</td>
<td>Relay Health: Institutional CPID – 1624</td>
</tr>
<tr>
<td>0070 – ClaimRemedi</td>
<td>Emdeon: Professional – SKMI1</td>
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<tr>
<td>00DL – Emdeon</td>
<td>Emdeon: Institutional – 12K38</td>
</tr>
<tr>
<td>00P1 - Gateway EDI</td>
<td>00NF - Netwerkes</td>
</tr>
<tr>
<td>0049 - PMG - The Physician's Billing Specialists</td>
<td>0049 - PMG - The Physician's Billing Specialists</td>
</tr>
<tr>
<td>00VV - QUADAX</td>
<td>00YB - Relay Health / McKesson</td>
</tr>
<tr>
<td>00ZA - Tri-Med Group</td>
<td>0099 - Western MI Business Services</td>
</tr>
<tr>
<td>005U - XACTIMED / Med Assets</td>
<td>999 files will be generated:</td>
</tr>
</tbody>
</table>

- "A" = Accepted  
- "E" = Accepted w/ Errors - no need to resubmit  
- "R" = Rejected - file must be corrected and resubmitted

**835RA files will be generated:**  
**File Name:** 5469  
**Sender:** DCHBULL  
**Availability:** Weekly on Thursday mornings  
**Note:** 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-9 code not in contract**
   Claim will reject

   **Problem:**
   ICD-9 code used is not a program-approved code.

   **Solution:**
   Re-submit claim with program-approved ICD-9 code.

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

   **Problem:**
   Primary Insurance paid more than the BCCCP rate.

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

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

   **Problem:**
   Primary Insurance paid less than the BCCCP rate.

   **Solution:**
   BCCCP will pay the difference between the insurance payment and the BCCCP approved rate. The client can not be balanced billed the remainder.

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 code billed is not a program-approved code.

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

6) **N5 or “166” - Prior Fiscal Year**
   Claim will reject

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

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

   **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 BCCCP 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:*
BCCCP 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 within 30 days of the claim getting into the system, it will then reject.**
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

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

Problem:
(1) Client is not enrolled;
OR
(2) Provider is billing for a BCCCP service using a WW or MCRCEDP ICD-9 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-9 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 MDCH 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: MDCH - BCCCP
DCH Accounting Division
PO Box 30437
Lansing, MI  48909

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

Common Billing Issues:
1. Client ID – should be the client's 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 MDCH 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 MDCH by December 31st of any fiscal year.

- For example, fiscal year 14 (FY14) ends on September 30, 2014 and fiscal year 15 (FY15) starts on October 01, 2014.
  - All original claims for fiscal year FY14 must be received no later than December 31, 2014. Any original fiscal year 14 claim received by MDCH after 12/31/2014 WILL BE rejected with N5 – prior fiscal year.
  - Original claims include claims waiting for EOBs.
  - Corrections for fiscal year 14 must be received by MDCH 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 **MDCH staff**
517-335-8752 – fax

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

Tory Doney                      Sam Burke
Department Analyst             Program Technical Analyst
**DoneyT@michigan.gov**        **BurkeS5@michigan.gov**
517-335-8854 – phone           517-241-6913 – phone
2015 Billing Manual

BCCCP Documents

www.michigancancer.org/bcccp

>> Billing & Reimbursement

- Rate Schedules
- ICD-9 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
- ICD-10 Codes

WISEWOMAN Documents

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

>> Program Management
>> Financial Resources

- Rate Schedule
- ICD-9 Codes
- Hold Codes – 835RA Adjustment Codes
- Revenue Codes
- Place of Service (POS) codes
- Procedure Code Reference Chart

Colorectal Documents

http://www.michigancancer.org/Colorectal/

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- Rate Schedule
- ICD-9 Codes
- Hold Codes – 835RA Adjustment Codes
- Revenue Codes
- Place of Service (POS) codes
- Procedure Code Reference Chart
- Billing and Reimbursement Policy