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Institutional Billing FAQs

*Updated 11/30/2018

1. **Do you have a copy of the contract language you can share that requires health plans to enter encounter data into CHAMPS? I'd be very interested to see what the requirements are.**
    a. On page 126 of the sample contract, Section D, the state defined the expectations of the MHP to enter accurate encounter data monthly, which must include "all fields required by MDHHS including, but not limited to financial data for all encounters… The Contractor's data must pass all required data quality edits in order to be accepted into MDHHS's data warehouse. Any data that is not accepted into the MDHHS data warehouse will not be used in any analysis, including but not limited to rate calculations, DRG calculations, and risk score calculations." In other words, the State expects all MHPs to enter accurate encounter data into CHAMPS, otherwise it won't be included in the capitation rates they receive from Medicaid to manage the benefits of their members.

2. **Does the contract language specify whether the health plan is responsible for their dental and behavioral health contractors' data?**
    a. On page 123 of the sample contract, it states "Contractor has full responsibility for the successful performance and completion of all Contract requirements as specified in Exhibit A, regardless of whether the Contractor performs the work or Subcontracts the services" (Section A, Flow-down of Contractor Responsibility). It goes on to specific that the MHP is "totally responsible for adherence by the Subcontractor to all provisions of the contract" and that MHPs "must monitor Subcontractor compliance of all delegated Contract responsibilities, requirements and standards managed through the Subcontractor." These provisions in the MHP contract are what the state use to make sure that subcontractors comply with all contract requirements and Medicaid policies, such as the institutional billing requirement and the requirement to submit encounter data to CHAMPS.

3. **How does the State know whether or not the encounter information is entered accurately and completely?**
    a. This goes back to the section of the contract referenced previously re: encounter data submission (page 126, section D). The state has an encounter quality initiative it uses to monitor the accuracy of MHP encounter data and runs periodic audits to verify the quality of encounter data the MHPs submit. This also helps the state identify where there are errors in the accuracy of the data to help diagnose and resolve issues that may be blocking the encounter data from processing in CHAMPS.

4. **If the State is aware of an issue, are they actually reducing the capitation rates?**
    a. Unfortunately, the process isn't as simple as, "is encounter data in CHAMPS? If not, then we're cutting you're rates." The MHPs must be given fair time to make the corrections they would need to be in compliance, and it is really important to recognize that when encounter data is not in CHAMPS, the first thing that needs to be done is to figure out why the encounter data isn't in CHAMPS. While there are many instances that encounter data shared by the state to health centers has missing data, almost universally there was an issue that needed to be resolved as to why the encounter data wasn't there – it wasn't just simply that the MHP didn't submit the data. Frankly, in most cases, the State has identified IT system issues on their end that needed to get fixed on their end that was "blocking" encounter data the MHP was submitting from getting through to CHAMPS. This is why it is also important that we keep working to identify where there are discrepancies so that the system fixes that are required can be developed and implemented.

5. Can you confirm that the state has asked the health plans to extend the timely filing limit?
    a. As of 8/1/2018, the state has asked the health plans to extend the timely filing limit until further notice

CODING

1. In regards to the new Medicare Telehealth rule effective 1/1/2019, will Medicaid follow this rule as well, and will it apply to MAT services?
    a. All of the telehealth coding recently introduced by CMS for the 2019 calendar year has not been reviewed yet. The state has coding meetings set up to determine how these services will be reimbursed to the health centers, and currently researching the services prior to making any decision for the upcoming year.
2. I would like to confirm for the procedure codes 59425/59426 since they are excluded are we billing these codes on a 1500 form vs the UB form
    a. For non-MIHP patients, services should be billed using the UB Form and there is no need to include PPS visit codes as the provider will be reimbursed accordingly

3. Where can you find a recent list of J Codes?
    a. FQHC Database, J Codes begin on page 58

4. When 2 G Codes with EM are reported, if vaccines are given do we apply modifier 25?
    a. Follow same modifier rules, there will not be an additional payment, you would receive PPS rate for EM
    b. Nurse visits would not count as face to face, submit claim as $0 for reporting

5. How should I submit a dental claim with multiple services on same DOS?
    a. When there are three D (Dental) codes on the same DOS; if the D codes count as an encounter, they will be paid with the exception of some services, for example x-rays which will pay at $0
        i. Example: Cleaning/X-ray same DOS; cleaning at $100, clinic will receive PPS rate

6. CCM CPT Code 99490 is not included on the list of qualifying visits. Is this something FQHCs will be paid for?
    a. Procedure code 99490 is not counted as an encounter.

7. For MIHP procedure codes, which are not on the qualifying visit list, when we bill to the MCO plans or Medicaid for MOMs coverage do we bill on a 1500 vs UB, or is Medicaid going to add the procedure codes to the qualifying visit list? Ex. 99402, H1000, H2000. Also, in Champs the eligibility shows the patient has MA coverage—vs MOMS/MIHP
    a. If a beneficiary has straight Medicaid and doesn't have the MIHP eligibility then the claims will have to be billed on the UB. If the beneficiary does have MIHP eligibility on the date of service then these codes should be billed on the 1500 as they have been excluded from policy 17-10.
    b. Also the codes listed 99402, H1000, H2000 are MIHP covered codes only resulting in denials if used for FFS MA beneficiaries. This is why they are not on the qualifying visit list.

8. Are you allowed to have two behavioral health visits from a Psychiatrist and an LMSW on the same day for the same patient? For example, can a patient come in and get a psychiatric evaluation from a psychiatrist 90792 and then get Psychotherapy 90832 from an LMSW on the same day?
    a. Both codes indicated fall under the same revenue code, therefore only 1 would be counted for Behavioral health

9. We have used the 0900 revenue on our Medicare behavioral health claims and I assumed Medicaid would also want the 0900 for behavioral health. I sent them the attached list with the highlighted behavioral health revenue codes and they responded stating we need to bill using the 0520 codes.
    a. United HC confirmed they have discovered that they had paid some claims billed with rev 0900 and G0466-G0470 in error. A system update was made that inadvertently caused payment of incorrectly billed claims. UNI is working on fixing this mistake and will be adjusting the affected claims. UHC will be sending notice to all centers affected by this error

10. Can you confirm if the cost of the actual glasses is included in the PPS reconciliation? (i.e. if they receive any payment for the codes 92340 or the v-codes, will that be netted out of the PPS?)
    a. For V Codes, Glasses and lenses are not pulled into reconciliation as they are billed through the contractor which is currently Classic Optical Laboratories. See section 1 of the Vision Chapter in the Medicaid Provider Manual.
    b. The 92340-92341 CPTs and payments would be pulled in during cost settlement. Payments for 92340/92341 would be included in cost reconciliation.
        i. These services are not carved out in the State Plan for FQHCs. Please note, the health plans may pay based upon their contract. If their contract states they must pay the fee screen rate, then the encounters may reflect that.

11. Our claims are going out under our Physical Therapist. At one point several months ago, we were told that claims cannot go out under our Physical Therapist; please clarify
    a. Per the FQHC chapter of the Medicaid Provider Manual, Section 4 – Billing;
        i. The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.

BILLING

1. Will Chiropractors get cost based reimbursement in FQHC's in Michigan?
    a. Certain Chiropractic Services are covered. It is recommended that centers review the Chiropractor Chapter of the Medicaid Provider Manual for specifics. http://www.mdch.state.mi.us/dchmedicaid/manuals/MedicaidProviderManual.pdf

2. For Dental if paid per diem how would we report/ reconcile for collection of add on services?
    a. All procedure codes included as part of the visit should be reported along with the per diem rate. The paid amount should always represent what the center has received (or expects to receive) for payment for that visit. If there are multiple procedure codes and thus visit lines in the filed health plan detail, the center should report the per diem rate on one line and make sure to inform their auditor that they received bundled payments. The auditor has to do a special bypass of the $0 payments reported on the other lines of the visit.

3. Are there more provider documentation requirements for Medicare Initial and Wellness visits, G-codes G0438 and G0439, than required when billing with the standard 9938- and 9939- billing codes?
    a. Here are the links which contain information for both exam types:
    IPPE
    AWL

4. Can Michigan FQHC's bill for LPC's?
    a. Yes. See MSA 13-13 page 2 of 3

5. If we have antepartum from 01/01/17-09/30/17- Do we split these into 01/01/17-07/31/17 and 08/01/17-09/3017? Or can we bill all on one claim due to the initial date?
    a. For the antepartum codes if the first date of service is prior to 8/1/2017 nothing is going to change, the entire claim should be billed on the 1500. If the first date of service is on or after 8/1/2017 then the entire claim would be billed on the UB, unless the beneficiary has MIHP services then those would also remain on the 1500.
    b. Per MSA 17-24 procedure codes 59425-59426 are not excluded, and should still be billed on the UB. Per MSA 17-24 clarification was made indicating that these 2 antepartum codes do not require a Clinic-PPS Payment code to be reimbursed appropriately.

6. How should a center submit claims for Vision Services?
    a. If the FQHC is performing the services, the vision services will need to be billed on the UB as well.

7. On the UB Claim Form, which number does Medicaid want placed as Health Plan ID in Field 51?
    a. In box 51, the number used by the health plan to identify itself belongs in this field. If the claim is coming to just FFS there shouldn't be anything in that field at all.

8. It is my understanding that if we document a well exam while a Medicare patient is having an acute or chronic visit that we will only be paid our PPS rate for a single visit and would not get any additional payment for the second
    a. When the patient is dual eligible patient, and you are performing a Medicare wellness exam, the Medicare wellness exam turns into an acute visit for a dual eligible. If so, you only receive the wellness Medicare G code payment. Even though it's wellness + acute, both MCR and MCD are daily rates and since the MCR reimbursement is larger than the MCD PPS, you only get the MCR– the State allows us to keep the payment from MCR greater than the MCD PPS. Please review the Medicare document that provides supporting information, look at G0468 description, last sentence.

OTHER

1. Are FQHCs allowed to collect co-pays from their patients with Medicaid and Managed Care Medicaid insurances?
    a. Medicaid copayments are exempt for FQHC's.
2. What are the necessary steps to take when a Dual Eligible member has opted out of Medicare Part B?
    a. Medicaid can only assist with Medicare deductibles and premiums once the beneficiary is enrolled in Medicare. Medicaid beneficiaries who did not receive automatic enrollment into Medicare Part A and/or Part B or declined coverage, should seek enrollment to take advantage of Medicaid assistance with Medicare out-of-pocket costs. Providers should refer beneficiaries who need to enroll in Medicare to their nearest Social Security office for assistance or suggest that they contact the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174 for health benefit information and counseling.

    b. As a reminder, balance billing a Qualified Medicare Beneficiary (QMB) is prohibited by federal law. All payments made by Medicare and Medicaid are considered payment in full. QMBs have no legal obligation for additional payment to the provider.