Michigan Department of Health and Human Services

STD/HIV Billing Toolkit: Frequently Asked Questions

1. Essential Community Providers

a. *Where on the Medicaid website can we find the list of essential community providers?*

You can find the latest list of Essential Community Providers (ECPs) here under Other Qualified Health Plan Application Resources: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html

b. *According to CMS "Facilities with no providers who hold one of the practitioner licenses identified in questions 13 or 14 of the petition (i.e., MD, DO, PA, NP, DMD, DDS) do not qualify to appear on our ECP list." I clarified this directly with CMS so strategies to address this will be welcome. Thank you.*

We need to work on a strategy to share provider levels of MD, DO, PA, NP, DMD or DOS with the sites that don't have this required oversight.

2. Credentialing / Licenses

a. *We have been in the credentialing process with the additional Medicaid carriers for 4 months and still have not received approval but are having a lot of clients with coverage come for services....my understanding is we can't bill those until we get approval?*

Many Health Plans will not allow you to bill as an in network provider until the credentialing process is done. It is wise to contact the individual Health Plan directly to inquire if you can get approval to bill as a non-network provider until the credentialing process is complete. Many plans do not want members to leave without services and may allow you to bill and get paid at Medicaid rates. Refer to the Key Contact list in appendix 3 of the toolkit to find the contact for each Health Plan.

b. *Just wondering can Licensed MSWs bill?*

Yes, licensed MSW's can bill for services rendered to Medicaid Members. Outreach should be made to the key contact (provided in the tool) at the Medicaid Plans in order to complete any process they have to allow the billing for MSW's. (also refer to question 3. C. below

- Conduct home visits to assess barriers to healthy living and accessing health care
- Set up medical and behavioral health office visits
- Help boost clients' morale and sense of self-worth
- Provide clients with training in self-management skills
- Provide clients with someone they can trust by being reliable, non-judgmental , consistent, open, and accepting
- Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives

c. *How likely will it be that Community Health Workers can bill for services, not just partner with health plans?*

It is very likely to bill for CHW services as there are plans paying currently. Work with each Health Plan to offer the provision of CHW services and work with them on a rate of payment.

d. *How does a person go about becoming a Certified Community Health Workers?*

Resources for certification of Community Health Workers can be found at the following site: http://www.michwa.org/resources/community-health-workers-101/.

e. *Will all non-credentialed providers need to be certified Community Health Workers?*

You will only certify those staff members who will be serving in the role of a CHW for example this may include peer counselors and nurses.

f. *Hi, any suggestions on how to get nursing visits paid for? Our health department nurses will administer depo injections, but we don't have any insurances that will pay for the nursing time or injection visit fee.*

   Here is one scenario with billing a nurse visit: a client arrives for depo, she is evaluated by an RN and found to have no additional needs or changes... the nurse can only bill for the depo and the injection fee, they can't bill a 99211 because there was no new intervention... secondly a new patient in STD evaluated and tested under protocol, an RN cannot bill a new client visit (99201)

99211 does not have any documentation requirements for the history, physical exam or complexity of medical decision making. The nature of the presenting problem need be only "minimal," such as monthly B-12 injections, suture removal, dressing changes, allergy injections with observation by a nurse. Depo would fall under this category but you would need to work with the Health Plan to obtain agreement to set up a billing protocol for this type of visit.

Code 99201 cannot be used to bill nursing visits.

g. *We have connected with Michigan Medicaid Policy, LARA and BCBS related to nurses providing STI services. The problem we continue to hit is that a nurse may not 'establish' a new client because it requires a level of assessment that is beyond the scope of practice.*

Unfortunately that is correct for a new patient which again would be billing the code 99201 as mentioned above. If a physician reviews the case and sets the protocol the nurse could bill 99211.

h. *If we bill for services that the RN provides such as STD screening under an approved protocol by our medical director, does the client have to establish care with a higher credentialed provider prior to billing?*

You would need to work with the Health Plans in your area but with a protocol by the medical director in place the Health Plan may allow the billing of 99211.

3. Plan Contracting and Negotiation

a. *Can you discuss when or if it might be advantageous to contract directly with a health plan for a "bundled" service versus individual service units?*

Bundled payments work out well of you can review your average length of time to care for someone and agree to a bundled amount that would net out to an amount that would be a net gain for you. Example: If the billing rate per service unit is billed in increments of 15 minutes and you always spend between 30 to 45 minutes and only on rare occasions spend 60 minutes it would be good to bundle at a rate between 30 and 45 minute unit cost to develop the bundled payment so you would gain on the majority and only lose on those rare occasions where visits go up to 60 minutes.

b. *My biller says she is not able to access the fee schedule for some of our carriers, what do I need to do to ensure she has access?*

Contact the key contact at the Health Plan and tell them you need access to their fee schedule and without it you can't see their members.

c. *For the Medicaid Health Plan Pilots, who would the insurance companies be contacting at the Local Health Dept's? Can the Local Health Dept's reach out to the insurance companies?*

Your organization should start with the person they worked with on the Medicaid Coordination Agreement for Medicaid. I would encourage you to reach out to the Health Plans sooner than later.

The following is taken from the new Health Plan requirements from the new Medicaid Health Plan Contract:

- Contractor (Medicaid Health Plans) agrees to establish a reimbursement methodology for outreach, engagement, education and coordination services provided by community health workers or peer support specialists to promote behavioral health integration.
- Community Collaboration Project
  Contractor must participate with a community-led initiative to improve population health in each region the Contractor serves. Examples of such collaborative initiatives include, but are not limited to community health needs assessments (CHNA) and community health improvements plans conducted by hospitals and local public health agencies or other regional health coalitions.
- Contractor must report on the effectiveness of its population health management initiatives including: Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level; Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP, or health promotion and prevention programs delivered by a community-based organization; changes in inpatient utilization, emergency department utilization, physician services and outpatient utilization, prescription drug utilization; outpatient CMHSP services; and selected health outcomes that are pertinent to the population served
- Services Provided by Community-Based Organizations

Contractor must, to the extent applicable, enter into agreement with community-based organizations to coordinate population health improvement strategies in the Contractor's region which address the socioeconomic, environmental, and policy domains; as well as provide services such as care coordination and intensive care management as needed and supported by evidence-based medicine and national best practices. Agreements must address the following topics:

- Data sharing
- Roles/responsibilities and communication on development of care coordination plans
- Reporting requirements
- Quality assurance and quality improvement coordination
- Plans for coordinating service delivery with primary care provider
- Payment arrangements

Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address social determinants of health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include but are not limited to:

- Conduct home visits to assess barriers to healthy living and accessing health care
- Set up medical and behavioral health office visits
- Explain the importance of scheduled visits to clients
- Remind clients of scheduled visits multiple times
- Accompany clients to office visits, as necessary
- Participate in office visits, as necessary
- Advocate for clients with providers
- Arrange for social services (such as housing and heating assistance) and surrounding support services
- Track clients down when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care
- Help boost clients' morale and sense of self-worth
- Provide clients with training in self-management skills
- Provide clients with someone they can trust by being reliable, non-judgmental , consistent, open, and accepting
- Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives

d. *Most private insurance carriers will not pay for supplies issued by the health department. Are there suggestions on how to get OCs covered during a visit?*

Work with the key contact at each plan so get approval to bill for these.

e. *We were recently funded again to provide HIV Counseling and testing. We can get this money and bill insurance?*

The funding you currently receive could be used for others who don't have insurance but if the member has insurance you should bill the Health Plan.

Grant funding may also be used to offset costs that are not covered by insurance. The Health Resources and Services Administration (HRSA) Ryan White (RW) program has established policy regarding income

generated and received as a result of the funds that some agencies receive through their MDHHS Ryan White awards. In the context of HRSA RW, program income is generated by recipients and sub recipients as a result of charging for services and receiving payment from third-party reimbursement. As the Affordable Care Act implementation continues, recipients and sub recipients may generate higher levels of program income. HRSA RW has determined that for RW recipients and sub recipients, the use of program income will be additive. Under the "additive" alternative, program income must be used for purposes for which the award was made, and may be used for allowable costs under the award. The following HRSA Policy link may be helpful. Note the term recipient refers to agencies that receive the funding directly from HRSA and sub-recipient would include local health departments or agencies receiving funding from MDHHS RW programs; http://hab.hrsa.gov/affordablecareact/pcn_15-03_program_income.pdf.

The Centers for Disease Control (CDC) provides funding for the MDHHS HIV Prevention and STD Programs. The CDC has not established guidance on program income generated from charging for HIV Prevention and STD services and receiving payment from third-party reimbursement. MDHHS recommends that similar to federal policy for RW and Family Planning programs; program income generated is to be reinvested back into the HIV and STD program(s) and used for the purposes for which the HIV Prevention and STD awards were made.

4. Coding

a. *We've been billing for a while and noticed the Z72.5X codes when the ICD10 change happened. We have an ethical issue about diagnosing clients as "heterosexual", "homosexual", or "bisexual". Is there an alternative set of codes we can use?*

ICD 10 did add specifics by adding .51-.53 to the Z72.5 series. While I understand you don't want to bill specifics keep in mind these codes are all protected and are part of the State of Michigan code suppression mandate so these can NOT be released on any EOB or other data.

b. *I thought only those who performed the test could bill the 80000 codes or lab codes. LHDs will collect the specimen but do not perform the test so we can't bill 87081, etc. Am I wrong?*

If the tests are sent out rather than you processing you would bill for the blood draw and not the test. This would also apply to swab, urine, etc.

5. Client Payment

a. *HRSA has specific requirements about collecting money from clients based on their income level. How should we address this?*

The Ryan White Program has a cap on charges for its clients based on their income. The cap on charges applies only to services provided to clients when Ryan White is the payer. Individuals who have a health insurance plan (Medicaid or private insurance) must use their health insurance to pay for services that the health insurance plan covers. The individual receiving care paid for by the health insurance plan is

responsible for the required co-pay; however, it is allowable for Ryan White programs to assist the client in paying his or her co-pay. Click here for additional information on Ryan White and the Affordable Care Act http://hab.hrsa.gov/affordablecareact/faqs.html