

Clinic Institutional Informational Virtual Training

5/30/2017

Frequently Asked Questions

Q: Is the Institutional format change for straight Medicaid claims or only for Medicaid claims that are secondary to Medicare?

A: The change to the Institutional format will affect all Medicaid clinic claims, including those going to the health plans.

Q: Will FQHC's be billing Medicaid the same way they currently bill their Medicare claims, using G codes?

A: Yes, all clinic providers will be required to have a payment code (G Code) along with a qualifying visit code reported to receive proper reimbursement.

Q: Medicare does not cover T1015, would the RHC's report a different claim to Medicaid to ensure proper Medicaid reimbursement?

A: MDHHS would expect the RHC claim to have the T1015 reported on the visit line for a crossover claim with a qualifying procedure code charges rolled up to the payment code line.

- Medicaid will still receive the entire claim as a crossover, including Medicare denied lines, as long as Medicare makes a payment on at least 1 line of the claim.

Q: How will the quarterly wrap payments process be impacted with MSA 17-10 in effect?

A: These payments will not be eliminated due to the MHP claims not being able to pay the clinic encounter rate at the time of adjudication.

Q: When filing the RHC cost report, is the MCO claim level detail needed through 9/30/2016, or through year end?

A: MCO claim detail is required through FYE 09/30/2016. It should be submitted using the HP_ Detail file used in previous years. HCRD will be pulling MCO claims 10/01/2016 forward.

Q: When completing the MMF, should the MCO date be tied to the MCO detail through 09/30/2016 or through year end?

A: The MMF should capture the full fiscal year of encounters and payment data. Therefore, if there is a fiscal period that crosses 09/30/2016, the MMF data may not tie out to the HP_ Detail.

Q: Is the MCO claim detail spreadsheet required at all now?

A: It is required up until 09/30/2016. **Do not submit any claims in the HP_ Detail with the DOS 10/01/2016 forward.** Doing so may result in a Reconciliation Report rejection.

Q: Does filing on the institutional claim form get rid of the annual MMF report?

A: Receiving the “wrap payment” on the Institutional claim form only applies to FFS at the moment. Therefore, cost reconciliation will still need to occur for the MCO data. So no, it does not get rid of the MMF report. Additionally, all FFS claims billed via the Institutional claim form will still need to be reported on the MMF.

Q: When reporting the qualifying visit lines (codes) what charges should be reported? Medicare requires a \$0.01 be reported.

A: Medicaid will not require a charge to be reported on the qualifying visit line(s).

Q: Where can the Revenue Codes be found?

A: Once published, the clinic revenue codes can be found by going to www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information

Q: Are the Medicaid Health Plans also requiring the Institutional billing format?

A: Yes, the institutional billing changes will affect all Medicaid billing including the health plans

Q: Where can the detailed list of all CPT and HCPC codes and corresponding “G” codes be found?

A: Once posted, these groups will be on the Medicaid Provider page under Provider Specific Information, under Clinic Cost Reimbursement.

Q: How should a procedure only visit be reported, such as a vaccine?

A: All services should be reported with appropriate revenue codes. A vaccine only visit does not qualify as a face to face, so simply bill the codes (needed for HEDIS measures) with an appropriate revenue code (see revenue code descriptions/NUBC guidelines).

Q: Where is a list of the services CPT/HCPCS that would receive an actual payment, if there are any such as “J” codes?

A: These groups once posted will be found on the Medicaid Provider website.

**Q: FQHC's with a Title X specialty must currently include a Taxonomy code at the header level for services to adjudicate appropriately, an example of this would be for oral contraceptives.
See MSA 11-25**

A: The Institutional Claim form does allow for Taxonomy codes so the taxonomy code requirement can continue. Continue to the taxonomy if policy mandates it.

Q: Will a rate letter need to be provided to the Medicaid Health Plans?

A: No. The Medicaid Health plans will have a set rate that is less than the PPR. HCRD will reconcile the difference based on the submitted encounter data.

Q: Are the Local Health Departments effected by MSA 17-10?

A: No. The Local Health Departments will continue to bill using the CMS 1500 (Professional Claim Format) as they are not paid on a PPR or AIR but instead are paid full cost under the Certified Public Expenditure (CPE) program.

Q: Will the OB 59425-59426 require the admission date on the claim form?

A: The 59425-59426 are antepartum care codes only so the beneficiary wouldn't have an admission date for these procedure codes.

Q: When a service is never covered by Medicare, will these cross over to Medicaid?

A: Claims will crossover to Medicaid only when Medicare makes a payment on at least one of the claim lines. If Medicare does make a payment Medicaid will receive the entire claim, even the lines that are non-covered by Medicare.

Q: Will the MCO claims be paid on the encounter rate, as well as the FFS claims?

A: Yes, however the MCO's are not able to be able to pay the full clinic encounter rate at the time of adjudication, resulting in the continuation of the quarterly wrap payments.

Q: Can the RHC manual be revised, as it states to follow Medicare guidelines, but usually Medicaid has a number of exceptions.

A: The wording of MSA 17-10 was updated to reflect "will align Medicaid with Medicare billing". This change was made due to Medicaid will not be following the Medicare clinic guidelines exactly.

Q: Will CHAMPS be ready to accept the new claims?

A: Yes, CHAMPS will be ready to accept the clinic claims unitizing the UB form as of July 1, 2017 for dates of service on or after July 1, 2017.

Q: Medicare requires the GC modifier to be utilized for some services. When these claims come over to Medicaid it states the GC modifier isn't valid, should we use a different modifier or does Medicaid want something else?

A: Medicare does require the GC modifier, and it can continue to be reported on the claim as Medicaid does not deny claims due to the GC modifier.

Q: How will this change effect MIHP claim/providers

A: MIHP claims will still be billed utilizing the professional CMS 1500 format, so MSA 17-10 does not affect these claims.