Clinic Billing FAQ

Questions compiled from the Clinic Billing: 101 Presentation Webinar held April 20, 2021

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Rural Health Centers (RHC's)

Q: Does the T-code need to be on line 1 of the UB or institutional claim format?

A: For RHC's the T1015 can be reported on any service line. If the claim counts as an encounter containing at least one qualifying visit code with a count of 1 or higher, the claim will be reimbursed on the T1015 service line only.

Q: Can all charges including lab charges for RHC be billed on the UB04 or institutional claim format?

A: All services rendered within the four walls of the clinic, using the clinic billing NPI must be reported on the institutional claim format, except for Maternal Infant Health Program services. If the codes are considered technical components the appropriate modifier must be reported. Some lab services may not reflect an encounter but could still be reimbursed at $0.00.

Q: When a Licensed Master Social Worker (LMSW) provides behavioral health services in a rural area but at a site that is not a designated an RHC, do the claims still require a cosigner? The claim is in the professional format?

A: For all non-clinic-related questions please contact Provider Support at 1-800-292-2550 or by email at ProviderSupport@Michigan.gov.

Q: When billing the T1015 code does the charge amount need to be billed on the T code or the Evaluation and Management (E/M) code?

A: The charges can be billed on the E/M codes or all rolled up into the T1015.

Please Note: The T1015 should never be priced at the facilities Perspective Payment Method (PPS)/ All-Inclusive Rate (AIR). All submitted charges should be the actual service charge(s).

Q: Do the Medicaid Health Maintenance Organization (HMO) providers follow Medicaid Fee for Service (FFS) rules?

A: The Medicaid HMOs must at least follow Medicaid FFS policy, but they can have more policies put in place as well. For clinic billing, the HMO's will/should never reimburse claims at the PPS/AIR but instead, pay the claims based on the Medicaid fee screens or the contracted rate between the HMO and the clinic. Some clinics may see that each HMO reimburses claims differently and that is to be expected depending on

the clinics contract with the HMO. The PPS/AIR will be reimbursed at the time of cost settlement for any HMO encounter claims (Medical or Dental).

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Federally Qualified Health Centers (FQHC's)

Q: Medicare claims are not getting crossed over to Medicaid. How do we resolve that?

A: Medicare crossover claim information can be found in the Medicaid Provider Manual, Coordination of Benefits chapter, Section 4- Crossover Claims.

For specific claim questions regarding crossover claims and why the crossover may not be occurring, please contact Provider Support by calling 1-800-292-2550 or email ProviderSupport@Michigan.gov.

Q: Why are our claims not being uploaded to HMOs?

A: For questions regarding Health Plan claims and being uploaded for cost settlement reasons please contact your Auditor.

Q: Do Medicare claims crossover to Medicaid if Medicare applies charges to the deductible and there is no payment from Medicare?

A: Yes, the crossover may still occur since Medicaid has liability on the claim due to the coinsurance or deductible amounts being reported.

Q: Should the original submitted charges for the G code be reduced by the amount of the commercial insurance OR should the full G code charge be submitted?

A: The claim should be submitted to Medicaid with the full claim amount submitted charges. Once the claim is adjudicated and if it is determined that the claim counts as an encounter, CHAMPS will reduce the reimbursement by subtracting the actual primary payment that was made.

Q: What should be the service date on an antepartum visit and what should the from and to date be?

A: The service dates for antepartum services depend on how the facility decides to bill, as long as Medicaid Policy is followed.

- The delivery date can be used as the To/From dates of service, with all other dates of service reported in the claim notes section. Or;
- A span date can be reported at the header to reflect the dates of service rendered. If this route is taken, remember that each date of service will need to be reported at each service line level for the claims to be reimbursed correctly.

Q: We bill telehealth (audio only) with modifier GT and place of service 02. We currently do not put a claim note on the claim, the claims are getting paid. Is the claim note really necessary as long as the GT modifier and 02 place of service is on the claim?

A: Per policy MSA 20-13 a claim note should be reported on the claim, letting MDHHS know that the services rendered were provided via audio-only. MSA Policy should always be followed due to post-payment review or audit. Providers may want to review the incorrectly billed claims with their legal team to confirm their next steps to reconcile the already billed and reimbursed claims.

Q: We have a few claims that are in suspended status. We are not sure why and what causes this. What can we do to get these claims processed?

A: For specific billing questions please contact Provider Support by calling 1-800-292-2550 or email ProviderSupport@Michigan.gov.

Q: We bill our claims on the institutional format, if we are using the Place of Service (POS) 02, will we still get our AIR for these?

A: For Institutional claims, there is no field to reflect the POS 02; however, the correct modifier should be used and if done via audio-only the claim note should be reflected as well. The AIR will be reimbursed if the qualifying visit code counts as an encounter with a visit count of 1 or higher on the Clinic Institutional Billing fee screen, and is also listed on the COVID-19 Response or Telemedicine fee screen. All clinic claims unless billing for dental or MIHP should be billed on the institutional claim format.

Q: If we bill a telehealth service and the patient comes in to give a sample will that service be paid as Medicaid Fee for Service? For example, a urine analysis .

A: Again, only the PPS/AIR is reimbursed for all clinic claims given the qualifying visit (E&M) code being billed in conjunction with a visit code has a count of 1 or higher. If the qualifying visit code has a count of zero, the claim will be reimbursed at $0.

Please contact Provider Support at 1-800-292-2550 or email ProviderSupport@Michigan.gov so we can better assist you in your question.

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Tribal Health Centers (THC's)

Please note all of the questions asked regarding THC's during the Clinic Billing: 101 webinar required additional, claim-specific review or clarification and were addressed on a 1-on-1 basis.

For questions regarding THC billing, please contact Provider Support by calling 1-800-292-2550 or email ProviderSupport@Michigan.gov.

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Resources

- Clinic Billing Webinar: https://somdhhs.adobeconnect.com/pibuh5f93b62/
- Provider Support
  - Phone: 1-800-292-2550
  - E-mail: ProviderSupport@Michigan.gov
  - Webpage: www.Michigan.gov/MedicaidProviders

- Medicaid Provider Alerts: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448_78458---,00.html

- Medicaid Provider Manual: http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf