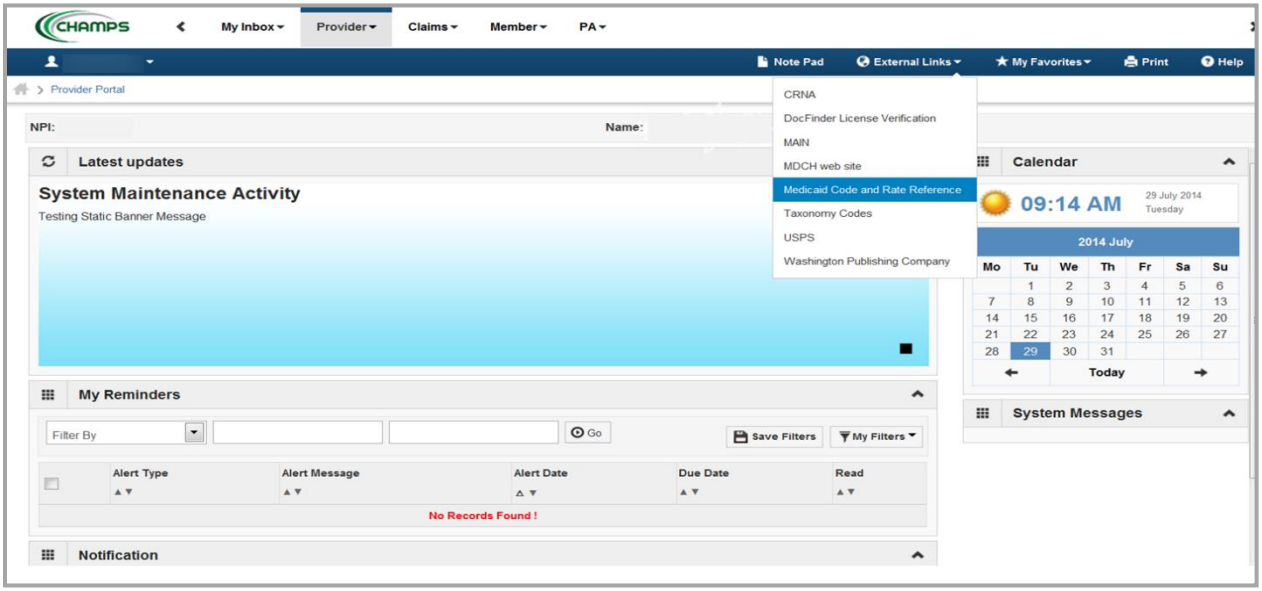
Medicaid Code and Rate Reference

Navigating through the Medicaid Code and Rate Reference tool

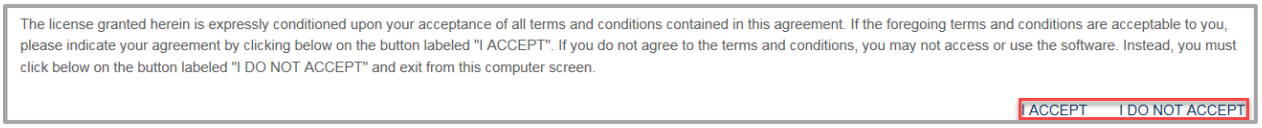
The Medicaid Code and Rate Reference tool is used for providers to view code details such as rates, limits, age restrictions, gender restrictions, modifier requirements, and prior authorization requirements. For outpatient hospitals the Medicare Addendum B, MDHHS wraparound list, and other resources must be utilized to accommodate pertinent information not loaded within the Medicaid Code and Rate Reference tool. **All Medicaid policy takes precedence over the Medicaid Code and Rate Reference tool.**

Accessing the Medicaid Code and Rate Reference tool:

1. First sign-in to Champs under the Billing NPI
2. Click on **External Links** tab
3. Select **Medicaid Code and Rate Reference**

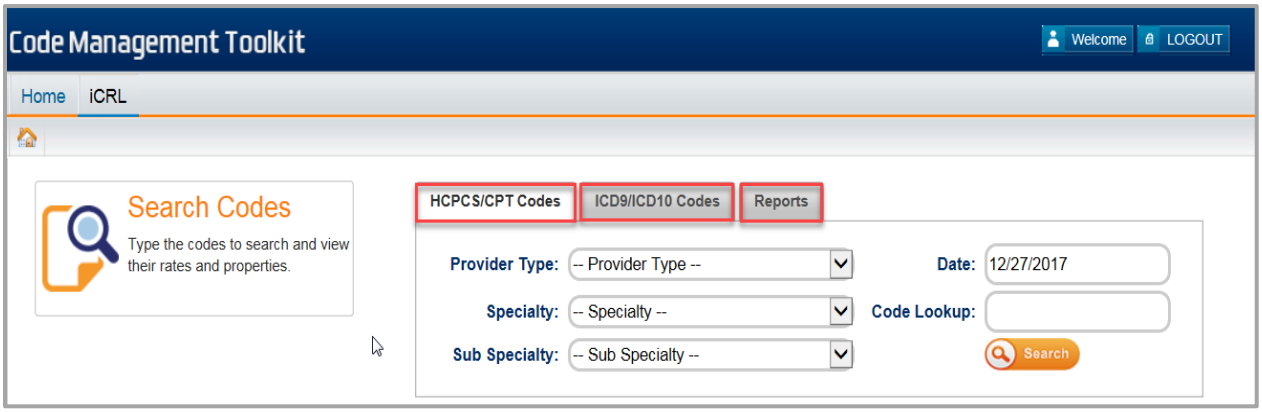


4. The user agreement screen will display, read through the **End User Point**:
   - If you **agree** to the terms, select **I ACCEPT**
   - If you **do not agree** to the terms, select **I DO NOT ACCEPT**. This will direct you back to the CHAMPS home page.



There are 3 ways to search within this tool:

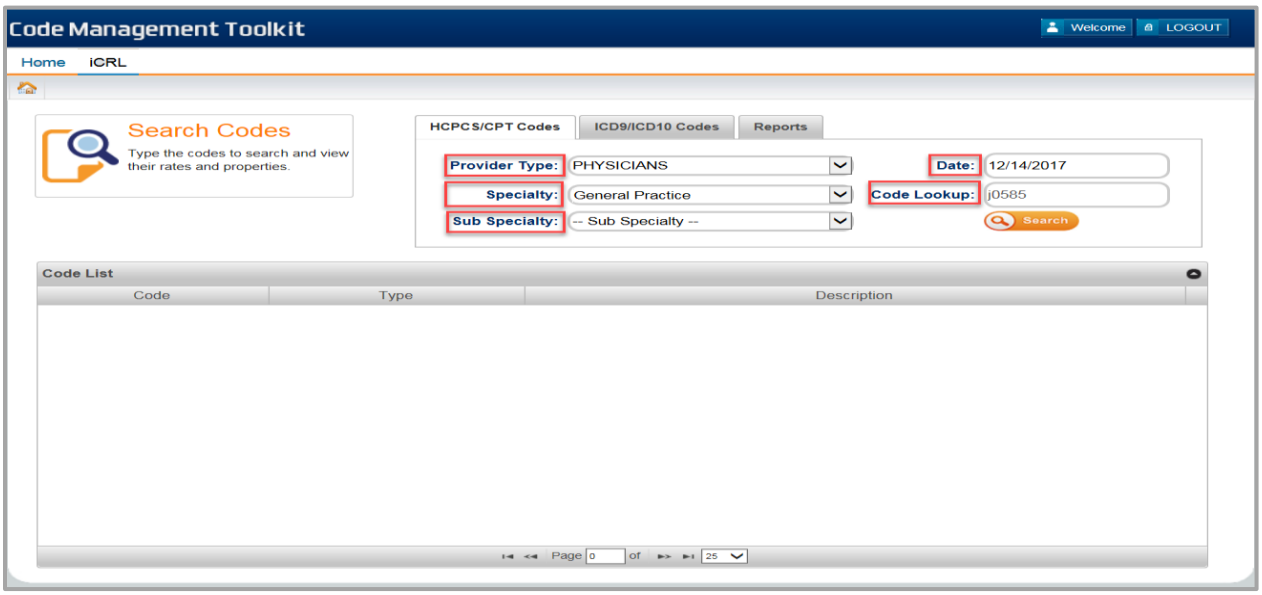
1. **HCPCS/CPT Code:** This function allows you to view code details when filtering by a specific Provider Type, Specialty, Sub Specialty, Date, and Code Lookup.
2. **ICD 9 or ICD 10 Codes:** This function allows you to enter in an ICD9/ICD10 diagnosis code.
3. **Reports (Generates an excel spreadsheet):** This function provides data file reports that are extracted from the Medicaid Code and Rate Reference tool. Generates in an Excel spreadsheet.



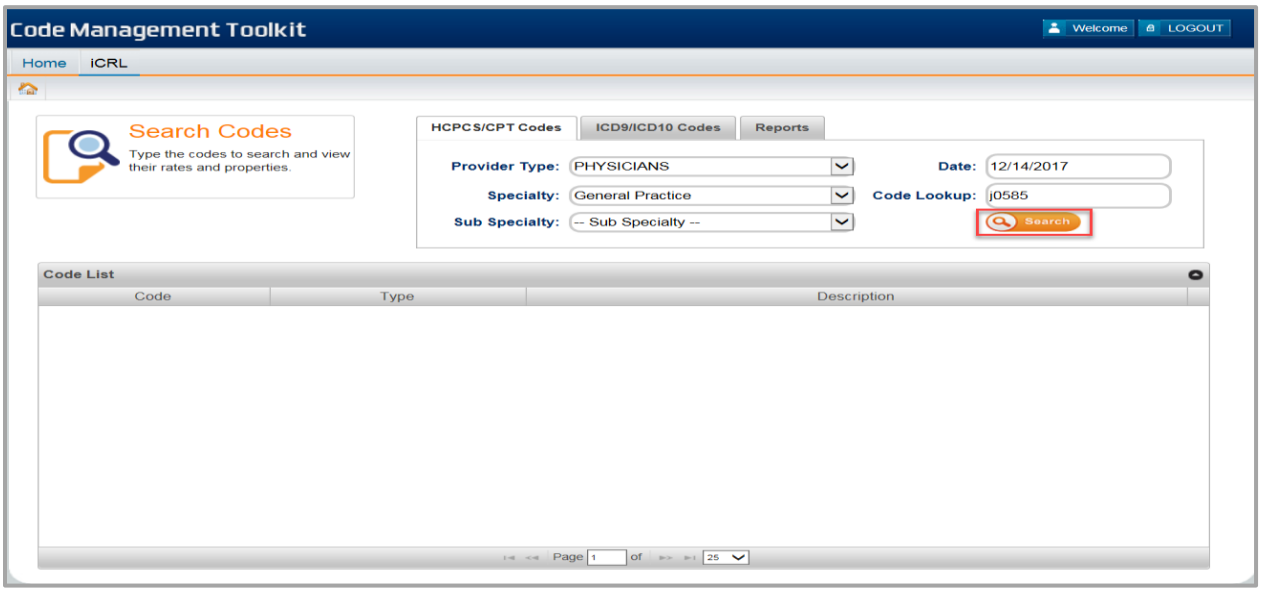
Searching by Individual HCPCS/CPT:

This function allows you to view code details when filtering by a specific Provider Type, Specialty, Sub Specialty, Date and Code Lookup.

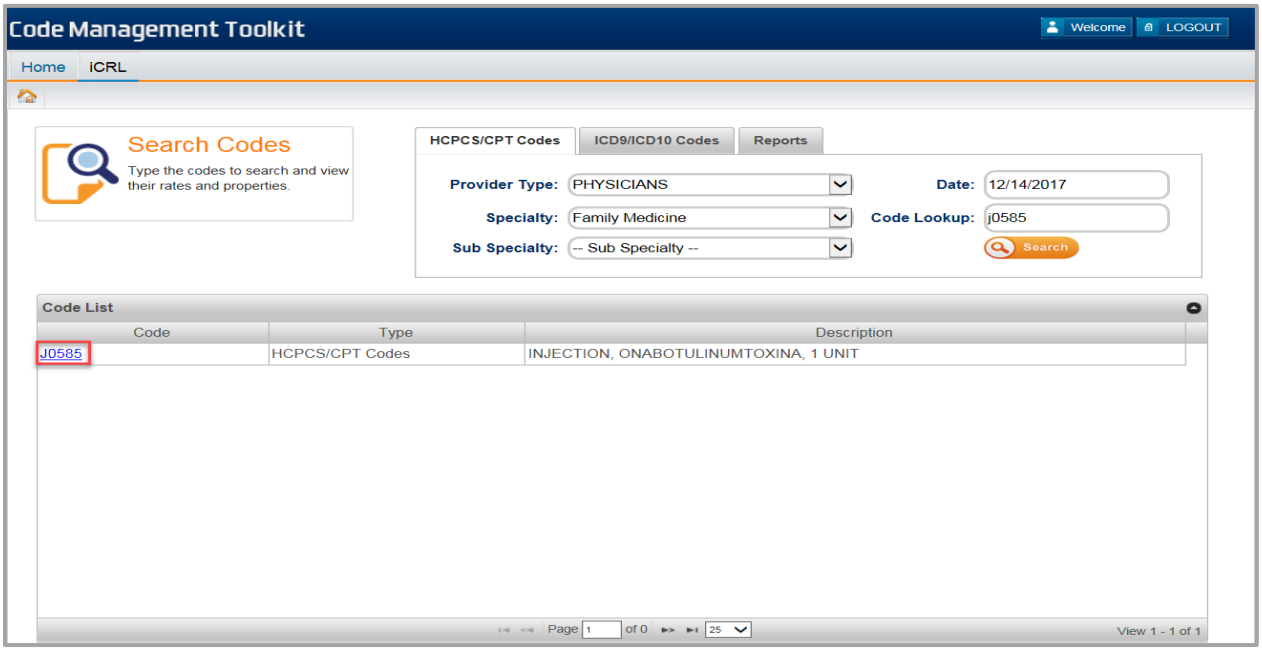
1. **Provider Type:** Select the appropriate **Provider Type** from the drop-down
2. **Specialty:** Select the appropriate **Specialty** from the drop-down
3. **Sub Specialty:** Select the appropriate **Sub Specialty** if applicable (This will provide further detailed information).
4. **Date:** Auto populates to the current date
    - Change the date to reflect the DOS
    - Cannot search for future dates
    - Can only go back 3 years prior to the current date
5. **Code Lookup:** Enter the specific code



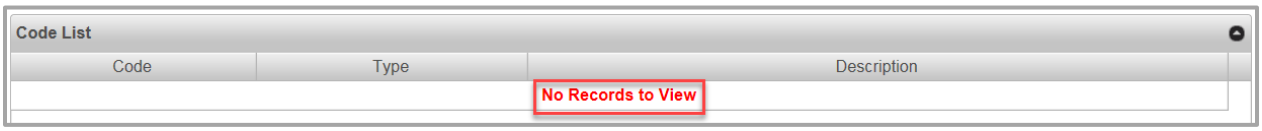
6. Click on **Search** once information is entered



7. To view code details, click the hyperlinked code

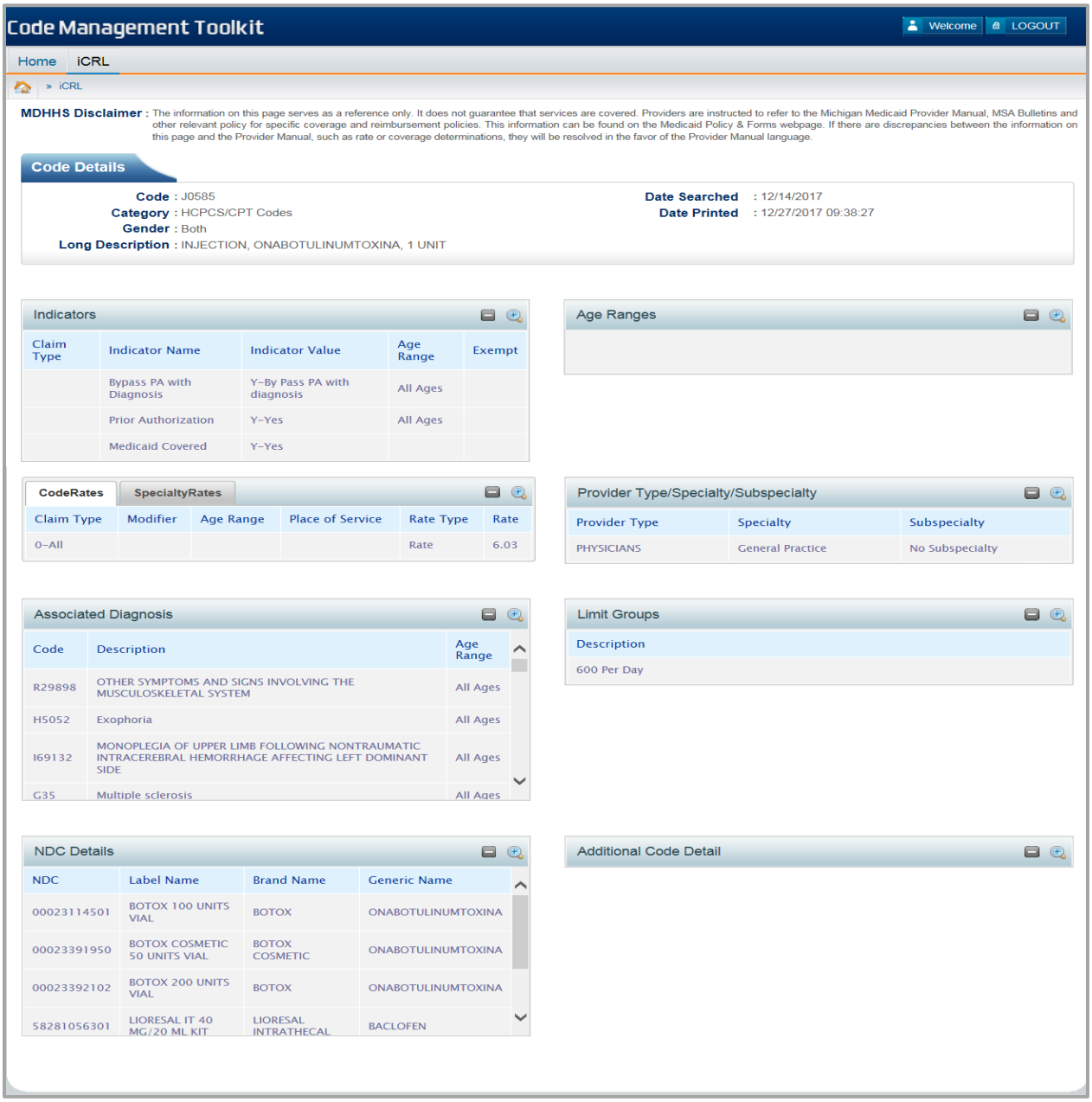


Please Note: If a code is entered that is incorrect or not a Medicaid covered benefit for the provider type No Records to View will display as a result.

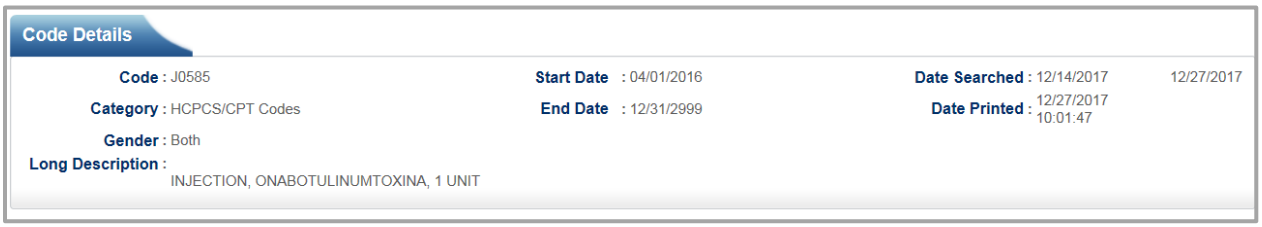


Please Note: When there is a magnifying glass within a section, providers are encouraged to click on it, as this may house additional information.

8. After clicking into the code the following screen will display, providing detailed information for;
   - Code Details
   - Indicators
   - Age Range
   - Code Rates/Specialty Rates
   - Provider Type/Specialty/Subspecialty
   - Associated Diagnosis
   - Limit Groups
   - NDC Details
   - Additional Code Detail



9. **Code Details:**
   Provides information that is associated to that code based on the date of service searched.



10. **Indicators:**
    There are a wide array of indicators as seen below;

Indicator Definitions:

- **Ambulance** - Identifies diagnoses that are recognized for emergency transport purposes.
- **Bypass PA with DX** - If "Y" is indicated, the prior authorization requirement is bypassed for specific medical conditions. For additional information, see the associated diagnosis codes representing these medical conditions.
- **CSHCS Qualifying** - Indicates diagnoses recognized by CSHCS that requires care by a medical or surgical subspecialist. Diagnosis alone does not guarantee medical eligibility for CSHCS. The individual must also meet the evaluation criteria regarding the level of severity, chronicity, and the need for annual medical care and treatment by a physician subspecialist. This is outlines within the CSHCS Chapter of Medicaid Provider Manual. Please refer to CSHCS, Section 8.1 Medical Renewal Period.
- **Documentation Required** – Additional information is required to process the claim (e.g., description of service, operative report, or consent form).
- **Hospital Discharge-Bypass PA** - If "Y" is indicated, then the prior authorization requirement may be bypassed for durable medical equipment if the date of service (DOS) of the claim is within 3 months of the hospital discharge date. See the Medicaid Provider Manual for additional policy details.
- **Manual Price** - A rate has not been established and the procedure code/service is priced manually.
- **Medicaid Covered** - The procedure code/service is recognized by the program; however, additional coverage restrictions (e.g., provider type or benefit plan) may apply. See the Medicaid Provider Manual for additional policy details.
- **Modifier Required** - The identified modifier must be reported on the claim.
- **Prior Authorization** – The procedure/service requires a prior authorization.
- **Supplies/DME – Per Diem** – If "Y" is indicated, then the medical supplier should not bill for the item; it is considered as part of the Nursing Facility per diem rate.
- **Tooth # Required** – The procedure code/service requires the specific number of the tooth to be reported on the claim.
- **Tooth Surface Required** – The procedure code/service requires the specific tooth surface to be reported on the claim.

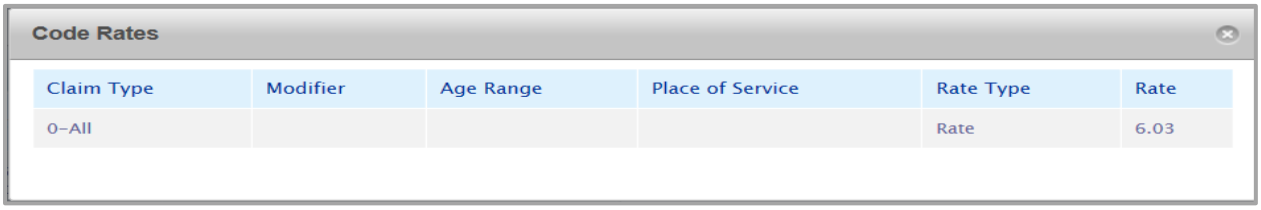
11. **Age Range:**
    Will list any age restrictions or parameters for the code

Age Ranges

Claim Type	Spl/Sub Spl	Modifier	Age Range	Exempt
			3 to 124 years	

12. **Code Rates/Specialty Rates:**
    Code Rates: Will show the reimbursement for the procedure based on the provider type selected. There could be multiple rates listed if there are things that effect the reimbursement i.e.: modifiers or place of service

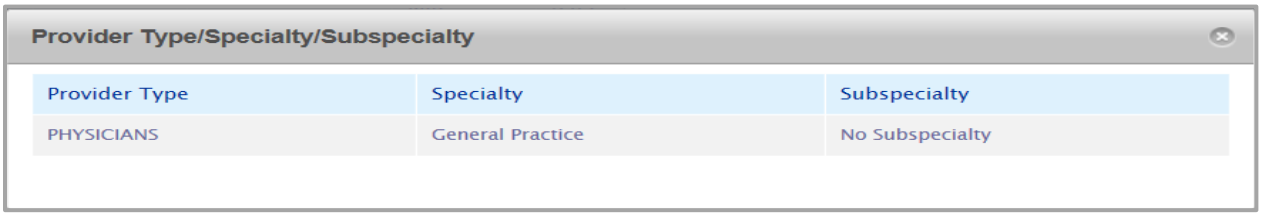
    Specialty Rates: Will show the reimbursement rates for things that may be paid differently. i.e.: primary care rate incentive, or county rates



Code Rates

Claim Type	Modifier	Age Range	Place of Service	Rate Type	Rate
0-All				Rate	6.03

13. **Provider Type/Specialty/Subspecialty:**
    The provider type that choosen for the procedure



Provider Type/Specialty/Subspecialty

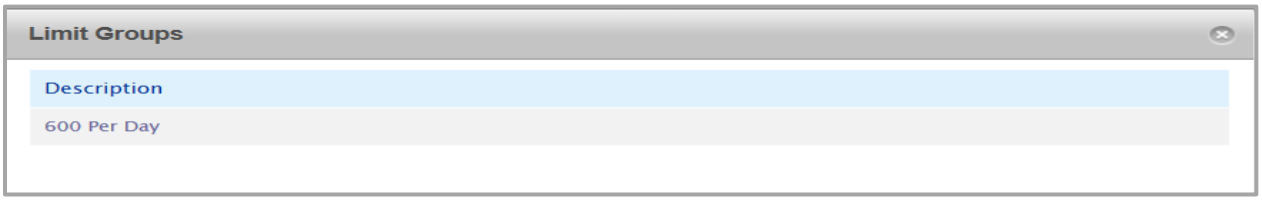
Provider Type	Specialty	Subspecialty
PHYSICIANS	General Practice	No Subspecialty

14. **Associated Diagnosis:**
    If the “Bypass PA with DX” Indicator has yes, then the dx codes in this field will bypass the PA requirement. This should not be confused with dx that support medical necessity, those dx codes are not published.

Associated Diagnosis

Code	Description	Age Range
R29898	OTHER SYMPTOMS AND SIGNS INVOLVING THE MUSCULOSKELETAL SYSTEM	All Ages
H5052	Exophoria	All Ages
I69132	MONOPLEGIA OF UPPER LIMB FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE AFFECTING LEFT DOMINANT SIDE	All Ages
G35	Multiple sclerosis	All Ages
I69251	HEMIPLEGIA AND HEMIPARESIS FOLLOWING OTHER NONTRAUMATIC INTRACRANIAL HEMORRHAGE AFFECTING RIGHT DOMINANT SIDE	All Ages
M62831	Muscle spasm of calf	All Ages
R498	Other voice and resonance disorders	All Ages
G360	NEUROMYELITIS OPTICA [DEVIC]	All Ages
I69853	HEMIPLEGIA AND HEMIPARESIS FOLLOWING OTHER CEREBROVASCULAR DISEASE AFFECTING RIGHT NON-DOMINANT SIDE	All Ages
I69062	OTHER PARALYTIC SYNDROME FOLLOWING NONTRAUMATIC SUBARACHNOID HEMORRHAGE AFFECTING LEFT DOMINANT SIDE	All Ages

15. **Limit Groups:**
    Will show the CHAMPS limits for the code, does not include medically unlikely edits (MUE) which take precedence over MDHHS assigned limits



16. **NDC Details**:
    Any NDC that are associated to the code will show. Because NDC shows here it does mean that the NDC is rebateable or active

17. **Additional Code Detail**:
    Not currently used

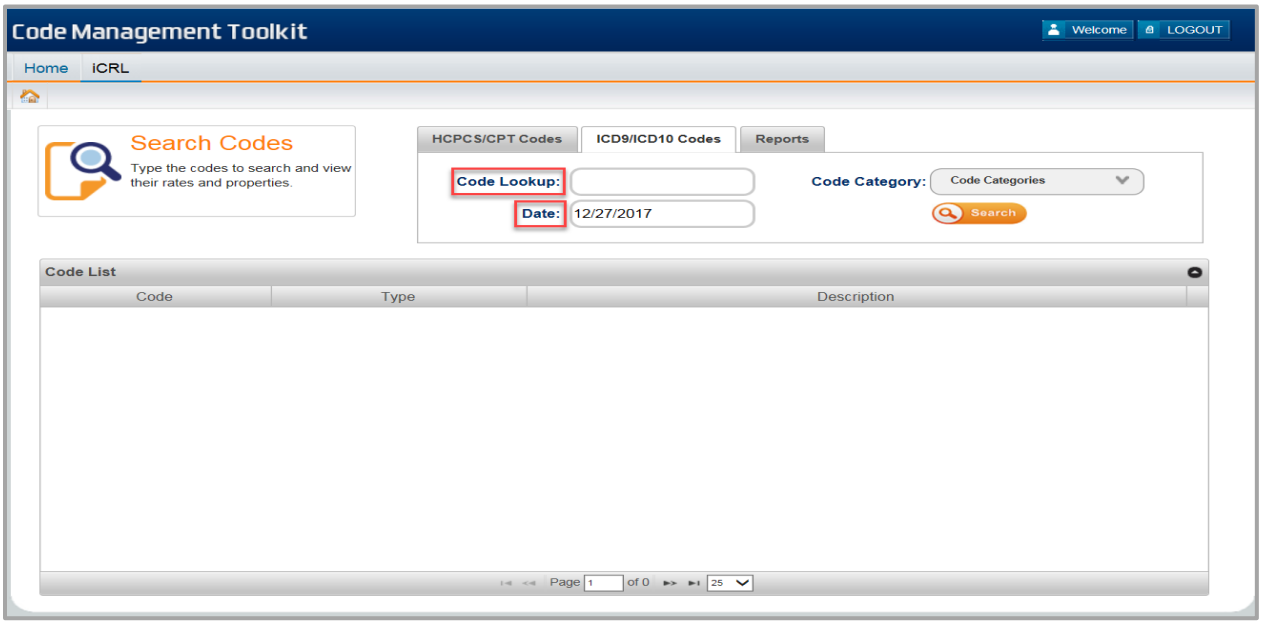
To return to the **Search** screen select the

button in the top right corner.

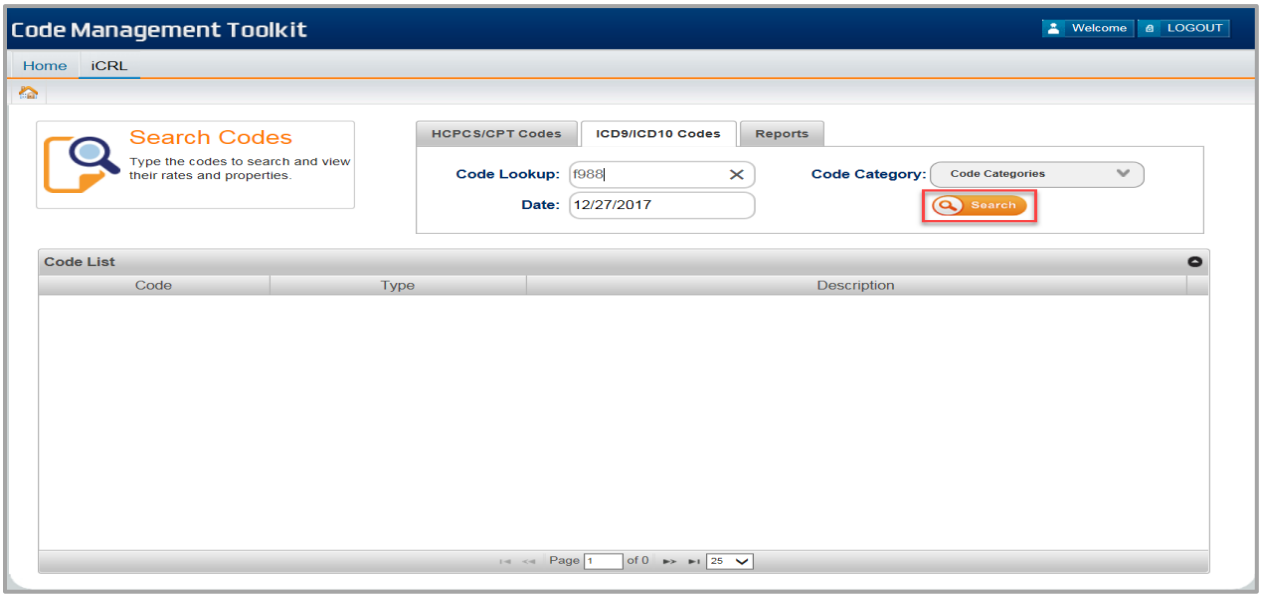
Searching by ICD 9 or ICD 10 Codes:

This function allows you to search diagnosis codes and surgical codes by entering in the following required fields:

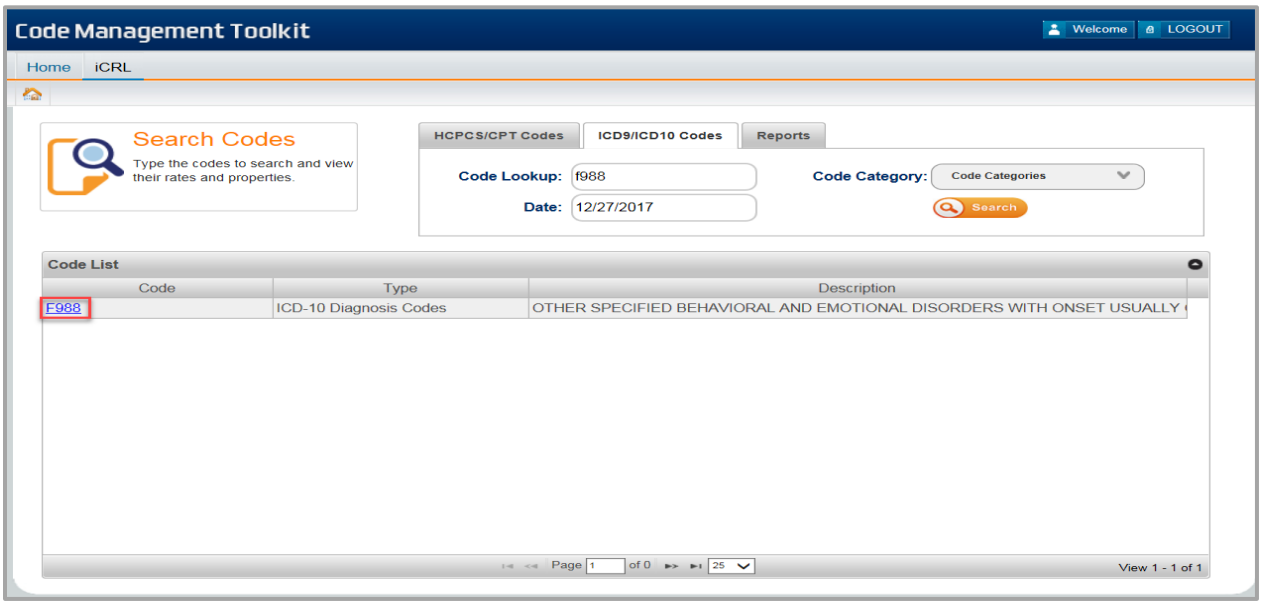
1. **Code Lookup:** Enter code with no decimals
2. **Date:** Auto populates to the current date
   - Change the date to reflect the DOS
   - Cannot search for future dates
   - Can only go back 3 years prior to the current date
3. **Code Category:** An optional field, but can limit the search results that populate
   - For Surgical Codes select ICD 9 or ICD 10 Procedure Codes
   - For Diagnosis codes select ICD 9 or ICD 10 Diagnosis Codes



4. Click on **Search** once information is entered



5. To view code details, click the hyperlinked code



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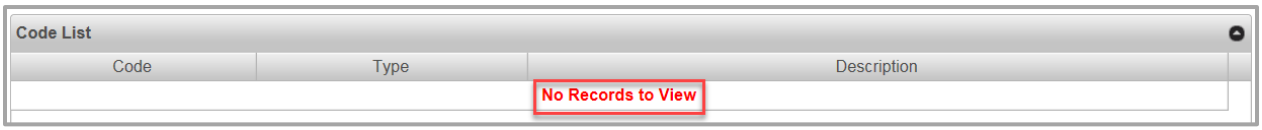
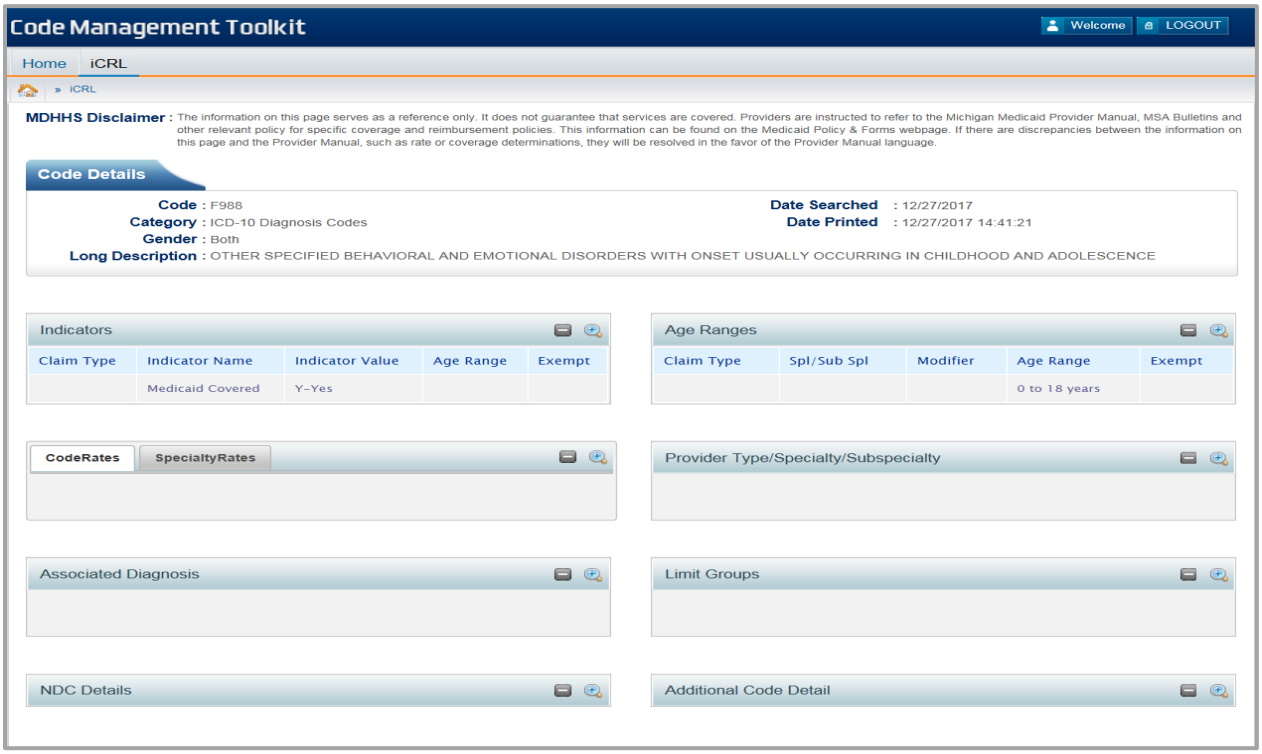


Please Note: When there is a magnifying glass within a section, providers are encouraged to click on it, as this may house additional information.

6. After clicking into the code the following screen will display, providing detailed information for:

7. **Code Detail:**
   This will show the information that is associated to that code based on the date of service searched.

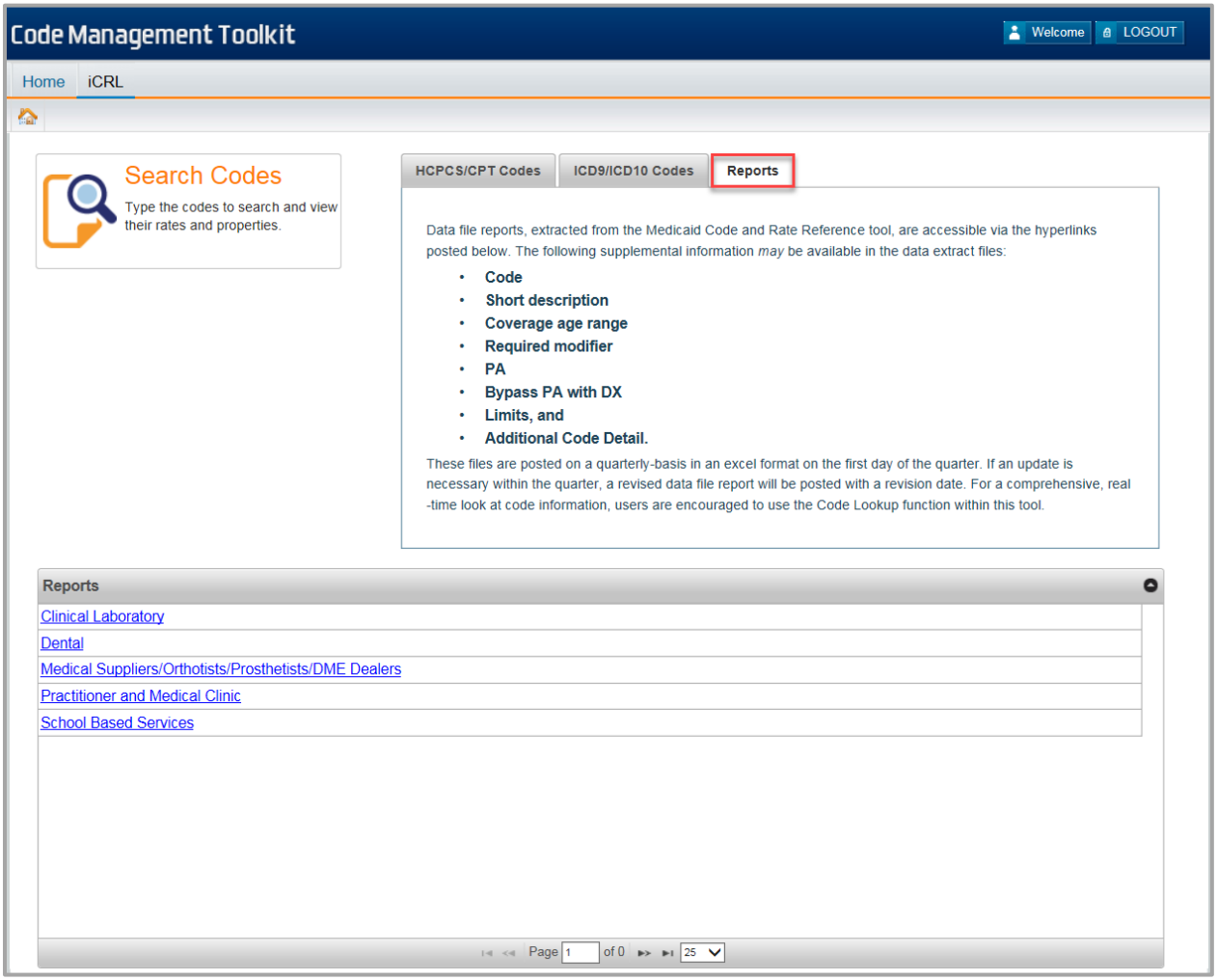


To return to the “Search” screen select the

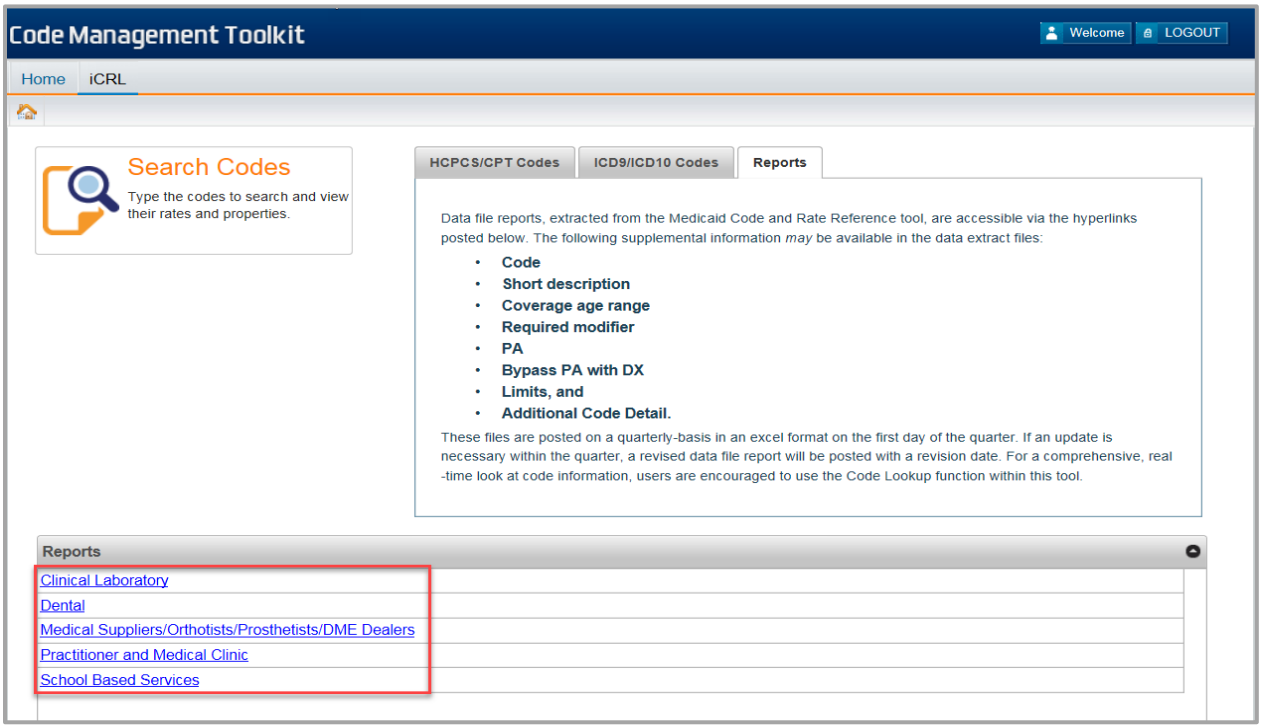
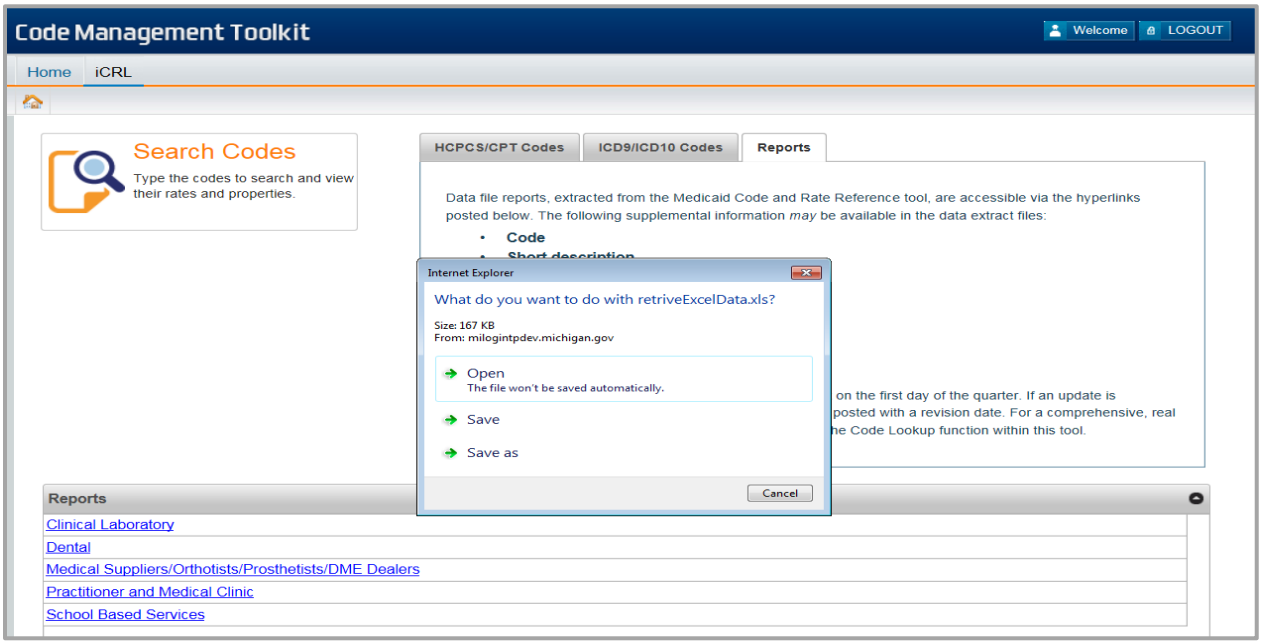
button in the top right corner.

Reports:

There is no search option under Reports. There are 5 different reports available based on provider type. The information available may vary in each report. The reports are updated on a quarterly basis, and as needed if there are code changes within the quarter. There is no historical log available to providers; therefore, providers are encouraged to save information or use the other code look-up functions.



1. Select the hyperlink of the report to open



2. A pop-up will appear with 3 options:
   - **Open:** Will open and download an excel spreadsheet to view
   - **Save:** Will download, and give the options to; Open, Open Folder, or View Downloads
   - **Save as:** Will allow user to save the file to the destination of their choice