Clinic Billing 102

"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

Table of Contents

MDHHS Michigan Department of Health & Human Services

Policy Updates

- Administration Name Change
- MSA 20-20: Rural Health Clinic MOU
- MSA 21-47: Attending Provider

MDHHS
Michigan Department of Health & Human Services

Administration Name Change

- Per Executive Order 2021-14 the Medical Services Administration (MSA) has been combined with Aging and Adult Services Agency and is now called the Health and Aging Services Administration (HASA).
- Health and Aging Services Administration (HASA) webpage
- Michigan Medicaid policies were published under the Medical Services Administration and were labeled MSA Year – Order of production, example MSA 21-54.
- Policies will now be published under the Michigan Health and Aging Services Administration and will appear as HASA Year – Order of production, example HASA 22-03.

MDHHS Michigan Department of Health & Human Services

Policy Updates: RHC MOU

- MSA 20-20

RHCs providing selected procedures in the RHC setting will be reimbursed pursuant to the payment methodology described under Attachment 4.19-B, Individual Practitioner Services section, of the Michigan Medicaid State Plan.

Selected procedures include:

- Endometrial Ablation (all methods)
- Hysteroscopy and Colposcopy
- Post-Partum Care
- Insertion and Removal of Non-Biodegradable Drug Delivery Implant

All other procedures performed at the RHC that are considered qualifying visits will be reimbursed at the PPS rate

MDHHS Michigan Department of Health & Human Services

Policy Updates: Attending Provider

- MSA 21-47
- Clinic Attending Provider Tip

Effective for Dates Of Service (DOS) on and after January 1, 2022, the following providers are allowed to be reported in the attending field (FL 76) for institutional invoices submitted by FQHCs, RHCs, Tribal FQHCs, and THCs:

- Physicians (includes podiatrists, optometrists, and chiropractors)
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Psychologists
- Clinical Social Workers
- Clinical Nurse Specialists
- Licensed Psychologists (Doctoral Level)
- Social Workers (Master's Level)
- Professional Counselors (Master's or Doctoral Level)
- Marriage and Family Therapists
- Limited License Psychologists (Master's or Doctoral Level)

Frequently Asked Questions

In-Depth Answers to Frequently Asked Questions (FAQ) Regarding Clinic Billing

Clinic 101 Webinar

Clinic 101 PDF

Clinic Billing FAQ

MDHHS Michigan Department of Health & Human Services

Frequently Asked Questions: RHC's

Does theT1015 have to be on all claims submitted?

Do Medicaid Health Plans (MHP) providers follow Medicaid Fee for Service (FFS) rules?

Can RHC claims automatically crossover from Medicare, so they don't have to adjust the claim for possible reimbursement?

Can all charges, including lab charges for RHCs, be billed on the Institutional claim format (837I)?

MDHHS Michigan Department of Health & Human Services

Frequently Asked Questions: FQHC's

- Please note: HASA 22-03 discusses telemedicine coding changes for the claim to be processed correctly.
- MDHHS will require modifier FQ to be appended in addition to modifier GT. When a provider submits modifier FQ for an audio only service, the provider does not need to include a note in the remarks section stating that the service was provided via telephone.

Do Medicare claims crossover to Medicaid if Medicare applies to the deductible and there is no actual payment made?

If telehealth is billed using audio only, is the note necessary when using the GT modifier and Place of Service 02?

What dates should be used for antepartum care?

Why do claims suspend?

MDHHS Michigan Department of Health & Human Services

Frequently Asked Questions: THC's

Is an Attending Provider NPI required on all Institutional Claim forms?

Can behavioral health and medical be billed on the same day and each reflect an encounter?

Why are dental claims paid at $0.00?

Does a payment code (G-Code) need to be on every claim submitted?

MDHHS Michigan Department of Health & Human Services

Frequently Asked Questions: Billing Guidelines Summary

Clinic Medical Billing

- PPS Rate = [Qualifying Visit Code (E&M) x (Qualifying Visit Count of 1 or >1)] + Visit Code (G-code) or T1015)
- PPS Rate ($0.00) = [Qualifying Visit Code (E&M) x (Qualifying Visit Count of 0)] + Visit Code (G-code) or T1015)

Clinic Medical Billing Antepartum Billing

- PPS Rate = 59425 or 59426 x (Qualifying Visit Count of 6 or 12)

Dental Billing

- PPS Rate = Qualifying Visit Code (E&M) x (Qualifying Visit Count of 1 or >1)
- PPS Rate ($0.00) = Qualifying Visit Code (E&M) x (Qualifying Visit Count of 0)

Dental Billing FQHC

- PPS Rate + APM = [Qualifying Visit Code x (Qualifying Visit Count of 1 or 2)] + "Yes" in APM Column

MDHHS Michigan Department of Health & Human Services

Billing Guidelines

- Perspective Payment System (PPS)
- Dental Billing Refresher
- Secondary Claims

MDHHS
Michigan Department of Health & Human Services

Billing Guidelines: PPS

- Washington Publishing Company
- Clinic Institutional Fee Screen
- Clinic Rate Letter Tip

Perspective Payment System (PPS) Visit Codes

- Per MSA 17-10 and 17-24 the appropriate Visit Codes (i.e., G-code & T1015) must be used for all services, as these are the only lines that will be reimbursed.
  - Exceptions: Antepartum Care and Dental Care.
- When a PPS visit code is billed with a qualifying visit code (i.e., EM code) the providers PPS rate (minus other insurance payment) will be reimbursed on the visit code line only, all other lines will pay at $0.00.

MDHHS Michigan Department of Health & Human Services

Billing Guidelines: Dental

- Dental Responsibilities at a Glance

PPS/AIR

- FQHCs and THCs receive the PPS rate / All-Inclusive rate (AIR) when performing dental service.
- RHC providers are not eligible for reimbursement for dental services.

Billing Format

- Dental claims are to be billed in the Dental ASC X12N 837D 5010 dental format.
- No visit code (G-code) is required for dental services, as these are billed on the Dental ADA Claim form.

Visit Count

- Dental services only receive 1 PPS rate/AIR per date of service per beneficiary.
- If the qualifying visit count is higher then 1, payment is calculated by taking the PPS rate/AIR x visit count.

MDHHS Michigan Department of Health & Human Services

Billing Guidelines: Dental Billing Refresher

- Clinic Billing FAQ

Dental Billing-Alternative Payment Method (APM)

- FQHC providers receive an incentive for rendering specific procedures in combination with each other.
  - An additional dollar amount is received on top of the PPS rate.
  - THC providers are excluded from this incentive.
- APM Follows all the same guidelines as clinic dental billing.
- Alternate Payment Method (APM):
  - Dental codes eligible for the APM are listed on the Clinic Institutional Billing fee screens with a "YES" in the Dental APM Column.

Suggested MCO Reimbursement Rate: $69.40

Revised: 11/17/2020

Code	Short Description	Modifier	Age Range	Rate	Qualifying Visit Count	Dental APM	Excluded Procedure Codes	PPS Visit Code	Effective Date**
D3421	Root Surgery Premolar			$349.13	1	YES			
D3425	Root Surgery Molar			$374.85	1	YES			
D3426	Root Surgery Ea Add Root			$374.85	0				
D3430	Retrograde Filling			$73.50	1	YES			
D3999	Endodontic Procedure			M	1	YES			
D4355	Full Mouth Debridement			$43.26	1				

MDHHS Michigan Department of Health & Human Services

Billing Guidelines: Secondary Claims

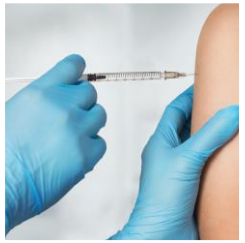
Medicare Crossover

- Claims billed to Medicare as a primary will automatically crossover to Medicaid, as long as Medicare makes a payment on at least 1 line.
  - Excluded from the crossover process between MDHHS and Medicare:
    - Totally denied claims
    - Claims denied as duplicates or missing information
    - Replacement claims or void/cancel claims submitted to Medicare
    - Claims reimbursed 100 percent by Medicare
    - Claims for dates of service outside the beneficiary's Medicaid eligibility begin and end dates
- For an RHC crossover to occur and be processed by Medicaid, the T1015 must be added to the Medicare claim and priced at $0.01.
- Claims billed to Medicare on the CMS-1500 form and then crossed over to Medicaid will be denied.
  - After the denial, providers need to rebill this claim on the UB-04 reporting the other insurance for the claim to adjudicate correctly.

Billing Guidelines: Secondary Claims

MDHHS will process all clinic claims that count as a face-to-face encounter by taking the PPS rate and subtracting the actual payment made by the primary.

For secondary claims, MDHHS will still only reimburse on the visit line (unless antepartum, dental, or MIHP), even if its only priced at a $0.01.



Medicaid Lesser of Logic has been waived for all clinic secondary claims including Medicare Crossover, unless billing for Covid-19 vaccine or specimen collection or stand-alone codes in the FQHC/RHC signed APM.

Primary CARCs and RARCs are taken into consideration. Ensure you are billing the primaries correctly and report exactly how the primary did within the other insurance information on the claim.

MDHHS
Michigan Department of Health & Human Services

Common Denials

MDHHS
Michigan Department of Health & Human Services

Common Denials

CARC	RARC	Why is this denial occurring?	How to Resolve the denial:
183	N574	The Provider Type is not allowed for Referring/Ordering/Attending provider.	MSA 21-47 was intended to reduce these issues, but prior to 01/01/2022 the Attending provider must be an MD or DO. Adjust the claim and add the Attending MD or DO in the Attending NPI field. Prior to date of service 1/1/2022
16	N307	The claim's timely filing notes don't match what the provider has been told.	If timely filing is bypassed for any situation, the note on the claim must match what the provider has been told. Adjust the claim and add the correct note to bypass timely filing.
16	M47	A historic (paid) Transaction Control Number (TCN) is missing or not found.	Claims can only be adjusted if they are already in paid status; denied claims cannot be adjusted. If the claim has been denied, rebill as a brand new (clean) claim. Review the Manage Claims: Adjust/Void Quick Reference Guide for additional information.
16	N34	This denial occurs when a professional clinic invoice has been received instead of an institutional claim form (UB-04).	Rebill the claim on the institutional claim form (UB-04).
16	N382	The Beneficiary ID is missing or invalid.	Add the Beneficiary's 10-digit Medicaid ID. If the ID is already on the claim, review it to ensure it is correct. Review the Eligibility Inquiry Quick Reference Guide for additional information.

COVID-19

- Clinic Policy Updates
- New APM's
- Public Health Emergency (PHE)
- Coronavirus (COVID-19) Resources

MDHHS
Michigan Department of Health & Human Services

COVID-19: Clinic Policy Updates

- MSA 20-09

- The PPS Rate will be reimbursed for Audio only, if the claim is billed appropriately for Telemedicine
  - The claim must have at least one qualifying visit code with a count of 1 or higher.
- Specimen Collection will receive the fee screen rate, when billed as a stand-alone service.
  - Per Michigan State Plan Amendment (SPA) 20-0009
- Medicaid does not cover the Medicare G2025 for distant site telehealth, for proper processing Medicaid rules must be followed.
  - G2025 Telemedicine Distant Site Provider Tip
  - G2025 Temporary Timely Filing Exception

MDHHS Michigan Department of Health & Human Services

COVID-19: New APM's

- COVID-19 Vaccine Provider Alert
- COVID-19 Response: Coverage of COVID-19 Vaccine Services (MSA 20-75)

COVID-19 Vaccine Administration Code

- The COVID-19 Vaccine administration code is a stand-alone service. It cannot be billed in conjunction with any other service, or it will be paid at $0.00.

Administration Fee

- When billing this service be sure to price the vaccine administration fee at the rate charged to be reimbursed the fee screen rate.

Claims Billed Prior to the SPA and APM

- For claims billed prior to the SPA approval and APM, MDHHS will reprocess. However, those claims must be priced correctly to receive proper reimbursement (if the administration fee is $0.00 the claim will be paid $0.00).

MDHHS Michigan Department of Health & Human Services

Public Health Emergency (PHE)

- www.Michigan.gov/Coronavirus
- MDHHS Epidemic Orders
- MDHHS Medicaid Policies
- Federal Public Health Emergency Declarations

- Policies labeled COVID-19 Response
- The Michigan Department of Health and Human Services (MDHHS) has issued many Medicaid Policy Bulletins and L-Letters which changed existing policy and processes under the guidance of the federal PHE. Policy bulletins and L-Letters issued as part of the PHE often indicate a change or return to the prior policy once the PHE has ended.
- In preparation for the PHE ending, providers are asked to:
  - 1. Review current "COVID-19 Response" policies;
  - 2. Be sure to verify beneficiary eligibility prior to services; and
  - 3. Encourage beneficiaries to update their contact information in MIBridges or contact their local county case worker.
- In addition, be sure to sign up for ListServ to receive COVID-19 response updates.

MDHHS Michigan Department of Health & Human Services

Coronavirus (COVID-19) Resources

MDHHS resources to keep providers informed about the Coronavirus (COVID-19) pandemic and the State of Michigan's response.

- Learn about our responses to Coronavirus (COVID-19) and find the latest program guidance. www.michigan.gov/coronavirus >> Resources >> For Health Professionals

- Additional Information:
  - COVID-19 Response Database
  - Telemedicine Database
  - COVID-19 Response MSA Policy Bulletins

- Questions About COVID-19?
  - Visit our Frequently Asked Questions page
    - Our most commonly answered questions can be found there and are updated often.
  - Call the COVID-19 Hotline at 1-888-535-6136
  - Email COVID19@michigan.gov

MDHHS
Michigan Department of Health & Human Services

Provider Resources

MDHHS
Michigan Department of Health & Human Services

Provider Resources

MDHHS website:
www.michigan.gov/medicaidproviders

We continue to update our Provider Resources:

- CHAMPS Resources
- Listserv Instructions
- Medicaid Provider Training Sessions
- Provider Alerts
- Provider Enrollment Website

Provider Support:

ProviderSupport@Michigan.gov
1-800-292-2550

Thank you for participating in the Michigan Medicaid Program