Clinic Billing 101

"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."

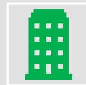
-Provider Relations

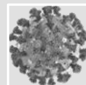
Table of Contents

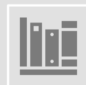
Clinic Type Overview

Policy Review

Billing Guidelines


Secondary Claims


COVID-19


Provider Resources

MDHHS
Michigan Department of Health & Human Services

Clinic Type Overview

- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)
- Tribal Health Centers (THC)

MDHHS
Michigan Department of Health & Human Services

Clinic Type Overview:

- Federally Qualified Health Centers (FQHC):
  - Qualify for funding under Section 330 of the Public Health Service Act (PHS).
  - Qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits

- Serve an underserved area or population
- Offer a sliding fee scale
- Provide comprehensive services (either on-site or by arrangement with another provider), including:
  - Preventive health services
  - Dental services
  - Mental health and substance abuse services
  - Hospital and specialty care

Clinic Type Overview:

- Rural Health Clinic (RHC)
  - Provider based-owned and operated as an essential part of a hospital, nursing home, or home health agency participating in the Medicare program.
  - Independent RHC-free-standing clinics owned by a provider or a provider entity. They may be owned and/or operated by a larger healthcare system, but do not qualify for, or have not sought, provider-based status. More than half of independent RHCs are owned by clinicians.

- Must be located in rural, underserved areas to receive certification
- Must be staffed at least 50% of the time with a Nurse Practitioner (NP), Physician Assistant (PA), or Certified Nurse Midwife (CNM). RHCs are required to provide outpatient primary care services and basic laboratory services.
- Reimbursed an All-Inclusive Rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.

Clinic Type Overview:

- Tribal Health Center (THC):
  - Operated by Tribes or Tribal organizations and specialize in caring for American Indians and Alaska natives. They are operated under the Indian Self-Determination Act.
  - Considered a 638 contract or compact

- Provides a range of services including:
  - Routine Care
  - Acute Care
  - Urgent Care
  - Chronic Care
  - Basic Laboratory Services
  - Behavioral Health

Policy Review

Why did clinic billing switch to the Institutional Claim format?

A review of MSA 17-10 and MSA 17-24, discussing changes to the billing format for Clinic providers.

MDHHS
Michigan Department of Health & Human Services

Policy Review

- MSA 17-10
- Issued March 31, 2017 with the intent of an effective date of July 1, 2017.

MSA 17-10

- FQHC, RHC, and THCs must use the ASC X12N 837 5010 institutional format when submitting electronic claims
  - Dental Claims will remain on the ASC X12N 837D 5010 dental format
- Policy 17-10 will affect clinic claims with a date of service on or after August 1, 2017 (date revised by MSA 17-24)
- All services that are rendered on the same date of service must be reported on a single claim, including Behavioral Health services
- Type of Bill:
  - FQHC and THC: 77X
  - RHC: 71X
- Appropriate revenue, payment, and qualifying visit codes are required for payment:
  - Modifiers must be reported with the Payment Code when applicable

Policy Review

- MSA 17-10 (Cont.)

Prospective Payment System (PPS) Visit Codes

- Providers will only receive one encounter per date of service, per beneficiary, unless services rendered are "different" and the correct modifier is used.
  - Medical, Behavioral Health (must be billed with appropriate visit codes (G-code).
  - Separate incident example: beneficiary was seen in an office visit for ear pain and then fell outside and returned with a broken ankle (the correct modifier must be used in this instance).

MDHHS
Michigan Department of Health & Human Services

Policy Review

- MSA 17-10 (Cont.)

- Additional Resources:
  - Medicare Claims Processing Manual

Medicare Crossover Claims

- Institutional billing allows Medicare primary claims to cross over to Medicaid.
- When a claim is crossed over to MDHHS, a remittance advice will be generated from the Fiscal Intermediary (FI) with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark does not appear on the fiscal intermediary's RA, a separate claim will have to be submitted to MDHHS.
- For more information regarding cross over claims, review the Medicaid Provider Manual, Coordination of Benefits chapter, Section 4- Crossover Claims

Policy Review

- MSA 17-24
- Issued June 30, 2017 informing providers of a delay to the clinic billing format changes.

MSA 17-24

- Delay of Clinic billing format change to Institutional
  - July 1, 2017 delayed to August 1, 2017
- Clarifications:
  - Clarification was addressed for MIHP and MI Care Team services.
    - Maternal Infant Health Program and MI Care Team services will continue to submit claims on the ASC X12N 837 5010 professional format.
  - Antepartum care payment codes were addressed, and clarification was made.
    - Antepartum Codes do not require a PPS Payment code as they are PPS Payment Codes themselves.

Policy Review

- MSA 20-20
- Issued May 1, 2020, informing Rural Health Clinics (RHC) of updated reimbursement methodology.
- Unlike FQHC and THC the G-codes are not required.
  - Instead of the G-code, RHCs must use the T1015 in order to receive reimbursement.

RHC Billing

- An RHC that is not reimbursed under an APM will have eligible qualifying visits reconciled to the Medicaid PPS rate as described in the Rural Health Clinics chapter of the Michigan Medicaid Provider Manual.
- Effective for dates of service on or after June 1, 2020, RHCs may agree in writing, through a Memorandum of Understanding (MOU), to be reimbursed under the APM as described in Attachment 4.19-B, Rural Health Clinic Services, subsection 5(b) 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

Billing Guidelines

- Header Detail
- Prospective Payment System (PPS)
- Qualifying Visit Codes
- Antepartum Care Billing
- Dental Billing

MDHHS
Michigan Department of Health & Human Services

Billing Guidelines

Header Detail

- Admission Source- can be found on the CMS webpage under Revised Bulletin MLN Matters Number MM6801.
- Patient Status - can be found on the CMS webpage MLN Matters Article SE0801.
- Attending Provider - Clinics must follow the UB-04 guidelines when reporting Billing and Attending providers.
  - An attending Provider must be an MD or DO
    - Exception: THCs are not required to report an MD or DO as their attending provider.
- If a span date is reported at the header, each date of service must be reported on each service line or the claim will be denied.

Billing Guidelines

Prospective Payment System (PPS) Rate

- Each clinic is assigned a PPS All-Inclusive Rate payment by Hospital and Clinic Reimbursement Division (HCRD).
- Each year clinics receive a rate letter letting them know of the All-Inclusive rate for the year.
- These letters come from HCRD and are not housed in the Document Management Portal (DMP)
  - Providers can request these letters from their auditor

MDHHS
Michigan Department of Health & Human Services

Billing Guidelines

Prospective Payment System (PPS) Visit Codes

- Per MSA 17-10 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

Prospective Payment System (PPS) Visit Codes (MSA 17-10)

- G0466 - FQHC/THC New Patient Visit
- G0467 - FQHC/THC Established Patient
- G0468 - FQHC/THC IPE or AWV
- G0469 - FQHC/THC New Patient Mental Health
- G0470 - FQHC/THC Established Patient Mental Health
- T1015 - RHC only
- 59425 - Antepartum care only (4-6 visits)
- 59426 - Antepartum care only (7 or more visits)

Billing Guidelines

Qualifying Visit Codes

- Claims are reimbursed at the PPS rate (minus other insurance payment) only if there is a qualifying visit code (i.e., EM code) billed in conjunction with a visit code (i.e., G-code & T1015).
  - Again, Antepartum and Dental are the exceptions

- Clinic Institutional Billing Fee Screens

Billing Guidelines

Qualifying Visit Codes

- The codes that count as an encounter are displayed on the Clinic Institutional Billing fee screens with a qualifying visit count of 1 or higher.
  - Each specialty (FQHC, RHC, THC) has their own fee screen

Michigan Department of Health and Human Services
Federally Qualified Health Center (FQHC) Reimbursement List
October 2020

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**
58356	Endometrial Cryoablation			$1,030.91	0		YES		
58555	Hysteroscopy Dx Sep Proc			$183.44	1				
58558	Hysteroscopy Biopsy			$784.67	1				
58562	Hysteroscopy Remove Fb			$224.05	1				
58563	Hysteroscopy Ablation			$1,101.63	0		YES		
59000	Amniocentesis Diagnostic			$68.74	1				
59020	Fetal Contract Stress Test			$39.62	1				

- Note, rates published are meant for health plans only.
  - Clinics are paid their PPS rate.

MDHHS
Michigan Department of Health & Human Services

Billing Guidelines

Antepartum Care Billing

- All clinics (FQHC, RHC, THC) are eligible to bill for antepartum care and receive their All-Inclusive PPS rate x the qualifying visit count
  - Note, Antepartum care codes are considered qualifying visit codes
  - The qualifying visit count will depend on what code is billed 59425 or 59426

Code	Short Description	Modifier	Age Range	Rate	Qualifying Visit Count	Dental APM	Excluded Procedure Codes	PPS Visit Code	Effective Date**
59020	Fetal Contract Stress Test	TC		$18.42	1				
59025	Fetal Non-Stress Test			$27.14	1				
59025	Fetal Non-Stress Test	26		$16.64	1				
59025	Fetal Non-Stress Test	TC		$10.50	1				
59160	D & C After Delivery			$137.09	0				
59425	Antepartum Care Only			$447.10	6				
59426	Antepartum Care Only			$795.20	12				
59430	Care After Delivery			$195.96	1				

MDHHS
Michigan Department of Health & Human Services

Billing Guidelines

Dental Billing

- 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.
- 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.
- Dental services only receive 1 PPS rate/AIR per date of service, per beneficiary; however, many qualifying visit codes (E&M) have a visit count higher than 1.
  - 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-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 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 = [Qualifying Visit Code x (Qualifying Visit Count of 1 or 2)]
- PPS Rate + APM = [Qualifying Visit Code x (Qualifying Visit Count of 1 or 2)] + "Yes" in APM Column

Secondary Claims

- Medicare Crossover
- Commercial Secondary Claims

MDHHS
Michigan Department of Health & Human Services

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.

Secondary Claims

Commercial 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
- For all clinic secondary claims, including Medicare crossovers the Medicaid Lesser of Logic has been waived.

COVID-19

All clinic policies related to COVID-19 are only valid through the Public Health Emergency (PHE), the department will notify providers once these policies are rescinded.

- www.Michigan.gov/Coronavirus
- MDHHS Epidemic Orders
- MDHHS Medicaid Policies

COVID-19

- MSA 20-13
- MSA 20-34
- MSA 20-57
- MSA 20-74
- MSA 20-75

- 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, that is approved for telemedicine.
    - Telemedicine Fee Screen
    - COVID-19 Response Fee Screen
- Specimen Collection will receive the fee screen rate, when billed as a stand-alone service.
  - Per Michigan State Plan Amendment (SPA) 20-0009
- COVID-19 vaccine administration is being proposed to receive the fee screen rate when billed as a stand-alone COVID-19 vaccine.
  - Proposal has been sent to CMS and is currently waiting CMS approval.

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
  - Actions for Caregivers of Older Adults During COVID-19 and supporting Frequently Asked Questions (FAQ) document
  - 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

Learn about each phase of the MI Safe Start Plan

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

MDHHS
Michigan Department of Health & Human Services