MONTANA HEALTHCARE PROGRAMS NOTICE

March 14, 2018

Outpatient Hospitals, Critical Access Hospitals

Effective Immediately UPDATE

Elimination of Provider-Based Clinic Status

Effective March 1, 2018, the Department will no longer recognize Provider Based Clinic status in reimbursing evaluation and management codes on the institutional claims (UB-04/838I transactions). This decrease is part of the reduction of $49 million general fund dollars to the Department of Public Health and Human Services budget.

Evaluation and Management (E&M) codes (with the exception of Emergency Room E&Ms) billed on an institutional claim will be set to a reimbursement amount of $0.00. When Montana Healthcare Program members are referred or sent from the clinic to the hospital to receive outpatient services (e.g. lab or imaging), providers will continue to bill these services on the institutional claim.

Your clinics that are within or outside your hospital walls will be considered independent clinics by Montana Healthcare Programs. Services provided by an individual physician or mid-level practitioner in the clinic must be billed on a CMS 1500 with place of service 11.

If your provider based clinic is not separately enrolled as a Group Clinic with Montana Healthcare Programs, we recommend the enrollment process be completed, for CMS-1500 billing.

The Department will update the Frequently Asked Questions section of this provider notice as necessary.

Evaluation and Management Codes Set to $0.00

Code	Description
G0463	Hospital Outpatient Clinic Visit
92002	Eye exam new patient
92004	Eye exam new patient
92012	Eye exam establish patient
92014	Eye exam&tx estab pt 1/>vst
95250	Cont gluc mntr phys/qhp eqp
99460	Init nb em per day hosp
99463	Same day nb discharge
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
G0245	Initial foot exam pt lops
G0246	Followup eval of foot pt lop
G0248	Demonstrate use home inr mon
G0249	Provide inr test mater/equip

Code	Description
G0402	Initial preventive exam
99381	Init Pm E/M New Pat Infant
99382	Init Pm E/M New Pat 1-4 Yrs
99383	Prev Visit New Age 5-11
99384	Prev Visit New Age 12-17
99385	Prev Visit New Age 18-39
99386	Prev Visit New Age 40-64
99387	Init Pm E/M New Pat 65+ Yrs
99391	Per Pm Reeval Est Pat Infant
99392	Prev Visit Est Age 1-4
99393	Prev Visit Est Age 5-11
99394	Prev Visit Est Age 12-17
99395	Prev Visit Est Age 18-39
99396	Prev Visit Est Age 40-64
99397	Per Pm Reeval Est Pat 65+ Yr

Frequently Asked Questions

Question	Answer
1. How is a claim for on-campus or off-campus clinic services billed to Montana Healthcare Programs?	1. Services furnished by practitioners within the clinic (on or off-campus) are billed on a CMS-1500.
2. When a blood draw is a completed in a clinic, but is then sent to the hospital lab to be processed, how does the claim look?	2. Reference lab billing is not allowed for Montana Healthcare Programs; therefore, the venipuncture is billed on the CMS-1500, and the laboratory service is billed on the UB-04.
3. How is a claim for a drug administered in a clinic billed to Montana Healthcare Programs?	3. Services furnished within the clinic by a physician or mid-level practitioner (on or off-campus) are billed on a CMS-1500.
4. How is a claim for oncology or infusion services furnished in a clinic billed to Montana Healthcare Programs?	4. Services furnished in the clinic by a physician or mid-level practitioner (on or off-campus) are billed on a CMS-1500.
5. How is a claim for oncology or infusion services furnished in outpatient hospital billed to Montana Healthcare Programs?	5. If your infusion or oncology services are provided in an outpatient department, not the clinic, bill on a UB-04 for all facility charges.
6. How is a claim for radiology billed?	6. If the radiology results are read by a practitioner outside of the clinic, that provider would bill the professional component (modifier 26) of the service on the CMS-1500. If the radiology test is performed in the clinic and both the technical and professional component are under the same

Question	Answer
	radiologist/practitioner, bill the with appropriate global procedure code on the CMS-1500. If the radiology procedure is provided in the hospital, the appropriate global procedure code would be billed. It is assumed the hospital is utilizing hospital staff to read the results of the procedure.
6. How will claims pay if we continue to bill with G0463?	7. The OPPS payment methodology bundles several procedure codes when billed with CPT G0463. G0463 is a valid code for Montana Healthcare Programs (reimbursed at $0.00); therefore, if it is on a non-crossover claim for dates of service March 1, 2018 or later, bundling will occur. If G0463 is omitted, the claim will price according to the line items on the claim.
8. Does the provider-based clinic change impact Critical Access Hospitals (CAH)?	8. Yes, but unfortunately at this time the claims payment system is not able to bypass the cost to charge logic when fee schedule rates are set at $0.00. CAHs will continue to show reimbursement on their remittance advice for E&M codes. This reimbursement mismatch will be resolved via cost settlement.
9. What happens if we continue to bill with revenue code 510?	9. On Medicaid primary claims, when revenue code 510 is billed with an E&M, the line will reimburse at $0.00. If revenue code 510 is billed with any other facility service(s), the system will reimburse at 80%. The Department recommends billing with the most appropriate revenue code for the service provided, given that Montana Healthcare Programs does not recognize provider based status.
10. Will provider-based changes affect Rural Health Clinics (RHC)?	10. The provider-based changes are not applicable to RHCs. RHC providers are clinics and are appropriately reimbursed via the PPS rate for clinic visits.
11. How will Medicare crossover claims process with Montana Healthcare Programs?	11. Montana Healthcare Programs reimburses coinsurance and deductible on outpatient crossover claims at the header level of a claim, not the line level. Outpatient crossover claims will be reimbursed based on the information received by Medicare, with Montana Healthcare Programs as the secondary payer. Professional services billed on the CMS-1500 will be adjudicated at the line level, based on the information received by Medicare with Montana Healthcare Programs as the secondary

Question	Answer
	payer.
12. What place of service does Montana Medicaid require for professional services provided in the clinic?	12. The clinics that are currently housed within or outside your hospital walls will be considered independent clinics by Montana Medicaid and the place of service required must reflect 'office' (place of service 11) when billing for services provided by physicians and mid-level practitioners.

Contact Information

If you have any questions, please contact:

Hospital Program Officer: (406) 444-7018

Critical Access Hospital / Rural Health Clinic Program Officer: (406) 444-4834

Physician/Mid-Level Program Officer: (406) 444-3995

For additional information, contact Montana Provider Relations at (800) 624-3958 or (406) 442-1837 or email MTPRHelpdesk@conduent.com.

Visit the Montana Healthcare Programs Provider Information website at www.medicaidprovider.mt.gov.