Procedures

Presented by Valerie St. Clair
Hospital Program Officer
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Core-Service Provided
Defining a Visit and Incidentals
Prospective Payment System (PPS) Rate
Billing Procedures
  ◦ Revenue Codes
  ◦ Services and supplies furnished as incidental to physician services
  ◦ Behavioral Health (Mental Health/Substance Abuse Services)
  ◦ Vaccines and Vaccine Administration
  ◦ Telemedicine
Plan First Member Eligibility ONLY
State Plan Amendments and Rule Amendments
Core-Services Provided

- Physician services
- Dental services
- Mid-level services
  - Nurse practitioner (NP)
  - Physician assistance (PA)
  - Certified nurse-midwife (CNM)
  - Clinical psychologist (CP), clinical social workers (CSW), licensed professional counselor (LCPC), and licensed addition counselor (LAC). Effective July 1, 2017.
- Clinical Pharmacist Practitioner (CPP)

Included – Incident to services and supplies

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Defining a Visit

- A FQHC/RHC visit is a medically-necessary face-to-face medical, mental health or dental visit.
- Visits may take place in the following locations:
  - The FQHC/RHC
  - The patient’s residence (including assisted living)
  - Nursing facility
  - The scene of an accident
- Members may have multiple visits on the same day.
  - After the first encounter, the member suffers an additional illness or injury requiring additional diagnosis or treatment; or
  - The member has a medical visit and mental health visit, or a medical visit and a dental or a mental health visit and a dental visit.
  - Add the appropriate modifier when there is a separate illness or injury.
Services and Supplies furnished as “Incident to” Physician’s Services

Incident-to services performed by non-core providers (lab techs, radiologists, LPNs, or other clinical personnel acting under the supervision of a physician, etc.) are included in the providers PPS rate and are not billable as a standalone visit even if the service is performed on a separate day from the core visit.

They include:

- Vaccine administration
- Service commonly rendered without charge or included in the clinic’s claim
- Basic lab services – essential to the immediate diagnosis and treatment of the patient
- Venipuncture
- Radiology, including ultrasound
- Outreach
- Transportation
- Allergen Immunotherapy
- Pharmacist – only visits of any kind
- Drugs and biologicals (e.g., influenza, pneumococcal)
Section 1902(bb) of the Social Security Act (Act), created by the Benefits and Improvement Protection Act of 2000 (BIPA), requires Medicaid to pay FQHC services under Prospective Payment System (PPS) rate. Payment is calculated on a per-visit-basis using “reasonable cost” based on the facilities Scope of Service.

- On September 24, 2001, DPHHS changed payment methodology to PPS rate.
- Payment is the same regardless of the length or complexity of the visit.

Rates are adjusted annually based on the Medicare Economic Index (MEI).

PPS rate must be adjusted to take into account any increase or decrease in the scope of service.
FQHC/RHC services must be billed either electronically or on a UB-04 claim form.

CMS-1500 wrong claim form for services furnished in an FQHC or RHC setting.

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FQHC/RHC core-providers who perform services in a hospital setting must bill the service on a CMS-1500 form using their own provider number.
Bill Type

- Bill type for FQHC is 77X
  - 771 – Clinic, FQHC, Admit Through Discharge
  - 779 – Clinic, FQHC, Final Claim

- Bill type for RHC is 71X
  - 711 – Clinic, Rural Health Clinic, Admit Through Discharge
Revenue Codes

RHCs and FQHCs must use the following revenue codes as specified by the Department. Check with Provider Relations to make sure they are valid for your facility. If invalid for your clinic, the use of these revenue codes will result in nonpayment.

512 – Dental
521 – Clinic Visit
522 – Home Visit
524 – Part A Visit at skilled nursing facility
525 – Not Part A Visit at skilled nursing facility
527 – Visit nurse services to a member’s home when in a home health storage area
528 – Visit to other non-RHC FQHC site (auto accident)
636 – HMK vaccine reimbursement
636 – LARCs
771 – HMK non-visit vaccine administration fee
780 – Telemedicine originating site
900 – Mental Health Visit
942 – Education Services
944 – Substance Abuse Services

Reimbursement is based on the revenue code, not the procedure code.

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Q – If Revenue code 521 is billed on more than one line will both lines reimburse the PPS rate?

A – No, Revenue code 521 will pay the first occurrence and bundle all subsequent occurrences. The only caveat is if the first occurrence of the revenue code 521 is listed with a non allowable procedure code. The line will deny and all subsequent lines will bundle and pay at $0.00.
Behavioral Health

- Mental Health
  - Revenue code 900
    - Appropriate procedure code

- Substance Use Disorder
  - Revenue code 944
    - H0001 – Assessment/Evaluation
    - H0004 – Individual Therapy
    - H2035 – Group Therapy

- Pending System Update – Licensed Addiction Counselors (LAC) will be required to enroll as a rendering only Medicaid Provider to furnish services in and FQHC/HRC setting only.
Vaccines and the administration of vaccines are not covered services in an FQHC or RHC facility and are not separately billable.

- Vaccines are provided by Vaccine For Children (VFC) Program
- The administration of vaccines is considered an incidental to the face-to-face visit with a core-provider and not billable separately.
HMK Members – Vaccine and Vaccine Administration

HMK eligible members are not entitled to the Vaccines for Children (VFC) program.

- If a HMK member receives a face-to-face visit with a physician or mid-level visit, vaccines will be paid and administration fees will bundle and pay at zero.
- If vaccines are administered without a face-to-face physician or mid-level visit, provider may also bill for vaccine administration fees using revenue code 771 and vaccine administration procedure codes.
- An **immunization-only** visit does not qualify to be reimbursed the PPS rate.
Title X and Medicaid

- If a member has Medicaid or Plan First those coverages should be used first.
  - Title X is to be used when a patient does not have insurance or the insurance does not cover the service
  - Title X is a payer of last resort

- Being Title X provider does not change your Medicaid billing or the way you provide services to a Medicaid member.
Plan First is limited plan of benefits, you can find the Plan First Covered Codes List at:
http://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst

All Plan First prescriptions must include a diagnosis code.

FQHC/RHC must bill on a CMS 1500 for Plan First ONLY member services.
Frequent Question

Q – If a member comes in for family planning service(s) can I bill on a CMS–1500 regardless of eligibility?

A – No, only Plan First member eligibility can be billed on a CMS–1500. If the member has overlapping coverage, e.g., Plan First and Medicaid or Medicaid Expansion. You should bill Medicaid, not Plan First.
Telemedicine

- **Originating–Site**
  - Revenue code 780
  - Procedure code Q3014
  - Reimburse – $25.10 (CY17)

- **Distant–Site**
  - Most appropriate revenue code and procedure code
  - GT modifier
  - Reimbursement – PPS rate

The originating and distant site cannot be the same pay-to provider or located in the same community.

Information regarding Telemedicine can be found in the General Information for Providers Manual.
Promising Pregnancy Care (PPC)

- Enhanced PPS rate for the educational aspect of PPC session provided in conjunction with an obstetric visit.
  - Approved providers will also be reimbursed the PPS rate for the face-to-face visit with a core-provider and;
  - $30.00/per member per education session
  - New rules are being implemented
  - Requested effective date July 1, 2017 – Pending CMS State Plan Approval

- Providers must get approval from The Department of Public Health and Safety to be eligible for reimbursement.
Additional information will be posted in a provider notice.
Promising Pregnancy Care (PPC)

- New Revenue Code – 969 (update)
- Procedure Code
  - 99078– Group Health Education

For more information contact Katie Bevan, Child and Maternal Health Nurse
  406–444–0950 or kbevan@mt.gov
Long–acting reversible contraceptive devices (LARCs)

- FQHCs and RHCs will be reimbursed separately for LARCs in addition to their PPS rate.
- LARC includes:
  - intrauterine devices (IUDs) and:
  - the birth control implants

Requested effective date July 1, 2017 – Pending CMS State Plan Approval
LARC\textss{s}

- Revenue code – 636
- Procedure Codes
  - J7297 – Liletta
  - J7298 – Mirena
  - J7300 – ParaGard
  - J7301 – Skyla
  - J7307 – Implanon/Nexplanon
  - J3490* – Kyleena

*Effective July 1, 2017, CMS issued a new temporary code Q9984, and then a permanent JCode will be issued and effective January 1, 2018
If you have not reported to Medicaid that you are a 340B provider you must do so.

340B Provider
- Must bill acquisition cost for the drug
- Currently, 340B drugs do not require National Drug Codes (NDC)

Non–340B Provider
- Reimbursement will be based on the hospital outpatient prospective payment system (OPPS). Pending CMS Approval
- Must include valid/rebateable National Drug Code (NDC) on claim.
When billing Medicaid, the required NDC is 11 digits. The NDC should be structured in the 5–4–2 format. Some manufacturers omit leading zeros in one of the three positions. This results in a 10 digit number, which is invalid. To ensure proper payment, the provider must add the appropriate leading zero to the affected segment of the format.

The table below indicates where the leading zero should be placed in three separate examples. **NDC Example Conversion: 10–Digit to 11–Digit Format**

<table>
<thead>
<tr>
<th>Leading Zero Location</th>
<th>10–Digit Examples</th>
<th>Add Zero</th>
</tr>
</thead>
<tbody>
<tr>
<td>5–digit segment</td>
<td>XXXX–XXXX–XX</td>
<td>0XXXX–XXXX–XX</td>
</tr>
<tr>
<td>4–digit segment</td>
<td>XXXXX–XXX–XX</td>
<td>XXXXX–0XXX–XX</td>
</tr>
<tr>
<td>2–digit segment</td>
<td>XXXXX–XXXX–X</td>
<td>XXXXX–XXXX–0X</td>
</tr>
</tbody>
</table>
Rebateable Manufacturers List

- http://medicaidprovider.mt.gov/

- Click on Site Index:
  - MATH Web Portal
  - Resources by Provider Type
  - Provider Enrollment

- Scroll down and select Rebateable Manufacturer:

<table>
<thead>
<tr>
<th>Manufacturer ID</th>
<th>Manufacturer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>00002</td>
<td>ELI LILLY AND COMPANY</td>
</tr>
<tr>
<td>00003</td>
<td>E.R. SQUIBB &amp; SONS, LLC.</td>
</tr>
</tbody>
</table>

- This list is updated quarterly
Clinical Pharmacist Practitioner (CPP)

- Core Provider ARM 37.86.4401 – Definitions
- Medicaid will allow reimbursement for Collaborative Practice Drug Therapy Management.
  - Face-to-face encounter
- CPP must meet the following requirements:
  - Clinical Pharmacist Practitioner rules as outline by the Board of Pharmacy
  - Maintain a collaborative practice agreement
  - Enroll as a Montana Medicaid Provider
- New rules and billing guidelines are being implemented
- Requested effective date July 1, 2017 – Pending CMS Approval

(Additional information will be posted to in a provider notice)
Clinical Pharmacist Practitioner (CPP)

- Provider must submit a change in scope of service to the department. *ARM 37.86.4406 – Service requirements – increase in service*
  - *New* Revenue Code – 779
  - Procedure Code
    - 99605 – New patient
    - 99605 – Established patient
Diabetes Prevention Program (DPP)

- Must be an approved provider by Public Health and Safety Department.
- Must adhere to the following:
  - Montana Medicaid State Plan, effective date 07/01/16, and Administrative Rule of Montana (ARM 37.86.5401–5404)
  - Group Sessions Only

If you have questions or need additional information about the DPP, please contact Public Health and Safety Department at 1–844–684–5848 or email chronicdiseaeprevention@mt.gov
Providers of DSME services must be recognized by:
- American Diabetes Associated (ADA);
- or accredited by American Association of Diabetes Educators (AADE);
- Must apply nationally and meet national standard of DSME (are required to reapply every 4 years); and
- Comply with Criteria and Requirements outlined in 42 CFR 140
- No approval will be required from Public Health and Safety
- Provider may be audited
DPP - Effective July 1, 2016 (must be an approved provider)
  ◦ New Revenue Code – 942
  ◦ Procedure Code
    • Group S9455

DSME –
  ◦ New Revenue Code – 942
  ◦ Procedure Code
    • Individual G0108
    • Group G0109
**New Revenue Codes**

Revenue Code 944 – Substance Use Disorders  
Revenue Code 942 – Education  
Revenue Code 779 – Clinical Pharmacist Practitioner  
Revenue Code 969 – Promising Pregnancy Care

**Medicaid has designated appropriate procedure codes to bill with these revenue codes for tracking and data collection**
Coming Soon!

✓ Provider Manual – Updates
✓ Provider Notices
✓ Claim Jumper Articles

http://Medicaidprovider.mt.gov

✓ FQHC/RHC – New and Updated Administrative Rules of Montana (ARM) – 37.86.4401–37.86.4420

http://mtrules.org/
Questions
Valerie St. Clair
Hospital Program Officer
406–444–4834
vstclair@mt.gov

Brenda Beardslee
Physician Claims Specialist
406–444–3337
bbeardslee2@mt.gov

Katie Hawkins
Hospital Section Supervisor
406–444–0965
khawkins@mt.gov

Katie Bevan
Child and Maternal Health Nurse
406–444–0950
kbevan@mt.gov

Becky Nettleton
Hospital Claims Specialist
406–444–7002
rnettleton@mt.gov

Conduent
1–800–624–3958

http://medicaidprovider.mt.gov