MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Tyler Wise

Phone Number: 517-284-1128

Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

Effective for dates of service on and after November 1, 2019, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Tribal Health Centers (THCs) must use the ASC X12N 837 5010 institutional format when submitting electronic claims to Community Mental Health Services Programs (CMHSPs), Integrated Care Organizations (ICOs), and Prepaid Inpatient Health Plans (PIHPs). Claims submitted with dates of service after this date will be rejected when submitted using the professional claim format (CMS-1500 and/or 837P). ICOs are currently required to accept claims on the institutional format. This bulletin will provide continued expectations for ICOs.

Reason for policy (problem being addressed):

Utilizing the institutional format for CMHSPs, ICOs, and PIHPs will align Medicaid with Medicare billing and allow clinics to receive the prospective payment rate for eligible encounters during cost settlement. The CMHSPs, ICOs, and PIHPs were unintentionally omitted from the distribution list for bulletins MSA 17-10 and MSA 17-24, which transitioned clinic billing to the institutional format.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and is budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No.

Does policy have operational implications on other parts of MDHHS?

Yes – the Hospital and Clinic Reimbursement Division; Provider Support; Claims Processing; Behavioral Health and Developmental Disabilities Administration.

Does policy have operational implications on other departments?

No.

Summary of input:

☐ controversial
☐ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 1840-Clinic	**Date:** July 29, 2019

Comments Due: September 3, 2019
Proposed Effective Date: November 1, 2019
Direct Comments To: Tyler Wise
Address: Program Policy Division/MDHHS/MSA/CCC 7TH Floor
E-Mail Address: WiseT2@michigan.gov
Phone: 517-284-1128 **Fax:** 517-241-8969

Policy Subject: Clinic Billing Format Change to Institutional; Prepaid Inpatient Health Plans and Integrated Care Organizations Clarification

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild

Distribution: Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Medicaid Health Plans, Community Mental Health Services Programs, Prepaid Inpatient Health Plans, Integrated Care Organizations

Summary: Effective for dates of service on and after November 1, 2019, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Tribal Health Centers (THCs) must use the ASC X12N 837 5010 institutional format when submitting electronic claims to Community Mental Health Services Programs (CMHSPs), Integrated Care Organizations (ICOs), and Prepaid Inpatient Health Plans (PIHPs). ICOs are currently required to accept claims on the institutional claim format. This will provide continued expectations for ICOs.

Purpose: Utilizing the institutional format for CMHSPs, ICOs, and PIHPs will align Medicaid with Medicare billing and allow clinics to receive the prospective payment rate for eligible encounters during cost settlement. The CMHSPs, ICOs, and PIHPs were unintentionally omitted from the distribution list for bulletins MSA 17-10 and MSA 17-24, which transitioned clinic billing to the institutional format.

Cost Implications: Budget neutral

Potential Hearings & Appeal Issues:

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**
Tribal Notification: Yes ☐ **No** ☒ **- Date:**	

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Comment001 **Revised 6/16**

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Medicaid Health Plans, Community Mental Health Services Programs, Prepaid Inpatient Health Plans, Integrated Care Organizations

Issued: October 1, 2019 (Proposed)

Subject: Clinic Billing Format Change to Institutional; Prepaid Inpatient Health Plans and Integrated Care Organizations Clarification

Effective: November 1, 2019 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this bulletin is to outline claim format clarifications for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Centers (THCs) when billing Community Mental Health Services Programs (CMHSPs), Integrated Care Organizations (ICOs), and Prepaid Inpatient Health Plans (PIHPs). ICOs are currently required to operate on the institutional claim format. This bulletin will provide continued expectations for ICOs. Utilizing the institutional format as described in this policy will align Medicaid with Medicare billing and allow clinics to receive the prospective payment rate for eligible encounters during cost settlement.

Clinic Billing Information

Effective for dates of service on and after November 1, 2019, FQHCs, RHCs, and THCs must use the ASC X12N 837 5010 institutional format when submitting electronic claims to CMHSPs and PIHPs. Claims submitted with dates of service after this date will be rejected when submitted using the professional claim format (CMS-1500 and/or 837P).

PIHPs and CMHSPs will be required to accept FQHC, RHC, and THC encounter claims on the institutional claim format beginning with dates of service on and after November 1, 2019. The institutional format requirement aligns with current clinic billing criteria referenced in bulletins MSA 17-10 and MSA 17-24. Medicaid bulletins can be accessed on the Michigan Department of Health and Human Services (MDHHS) website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

FQHCs, RHCs, and THCs are required to report detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line item charges listing the visit that qualifies the service for the prospective payment rate. Procedure code coverage information is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Clinic Institutional Billing.

Providers billing under the institutional format must submit all services rendered on the same day on one claim. When payment responsibility for services involves more than one entity, the provider must submit separate claims to each entity. Example: if a beneficiary enrolled in a Medicaid Health Plan receives both Substance Use Disorder (SUD) and non-SUD services in the same day, the SUD services are billed to the responsible payor and non-SUD services are billed to the Medicaid Health Plan. FQHCs, RHCs, and THCs may submit claims that span multiple dates of service, as dates are adjudicated separately.

The appropriate National Provider Identifier (NPI) information (e.g., billing provider, attending provider) is required on all institutional claims. The attending provider NPI belongs to the individual designated by the patient as having the most significant role in the determination and delivery of the beneficiary's care. For institutional billing, FQHC and THC providers should submit claims with Type of Bill 77x, and RHC providers should submit Type of Bill 71x.

MDHHS follows Medicare billing guidelines. FQHCs, RHCs, and THCs should refer to Medicare billing requirements for additional information. Refer to the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov >> Regulations & Guidance >> Manuals >> Internet Only Manuals to review Publication #100-04, Medicare Claims Processing Manual: Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers for additional details.

Revenue Codes

A complete list of covered and non-covered revenue codes is maintained on the Revenue Code Requirement Table accessible at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Outpatient Hospitals. Revenue code descriptions, code ranges, and coverage are subject to change.

Payment Codes

The following procedure codes ("Clinic – Payment Code") are appropriate for use on a claim:

Procedure Code	Code Description
G0466	FQHC new patient visit
G0467	FQHC established patient
G0468	FQHC visit, IPPE or AWV
G0469	FQHC visit, new patient mental health
G0470	FQHC visit, established patient mental health
T1015	Clinic visit, all-inclusive (RHC use only)

- Providers must continue to provide the appropriate modifier on claims in accordance with the CMS National Correct Coding Initiative. When necessary, the modifier must be present with the appropriate "Clinic – Payment Code."

Clinic – Qualifying Visits

Detailed HCPCS coding with the associated line item charges listing the visit that qualifies the service for the prospective payment rate and all other services furnished during the encounter are required. It is essential to document the services provided for quality measures. Encounter claims submitted with strictly the "Clinic – Payment Code" will not be eligible to receive the prospective payment rate. Conversely, encounter claims submitted without the "Clinic – Payment Code" and only the service line procedures will not be eligible to receive the prospective payment rate. Procedure code coverage information is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Clinic Institutional Billing. Procedure code descriptions and coverage are subject to change.

Clinic Reimbursement and Reconciliation

The prospective payment rate is established using the clinic's current prospective payment system or Indian Health Service all-inclusive rate methodology for provider rates. The prospective payment rate will be paid based on the revenue code and "Clinic – Payment Code" combination, limited by the encounter count per beneficiary/day (unless modifier 59 is utilized to indicate a subsequent injury or illness that requires additional diagnosis or treatment on the same day). Coding limitations and other historical edits continue to apply.

For eligible managed care encounter claims, providers will receive their prospective payment rate during the clinic cost settlement. Encounter claims must be submitted properly on the institutional form and "accepted" in the Community Health Automated Medicaid Processing System (CHAMPS) to receive consideration for the prospective payment rate. All required fields on the institutional billing form must be completed and meet billing, audit and clinic reimbursement standards.

For additional information, refer to the Michigan Medicaid Provider Manual, Rate Setting and/or Encounters section in the chapter for your specific provider type. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. Rate information will be loaded into the CHAMPS Medicaid Code and Rate Reference tool available under the external links.

Existing Medicare crossover and third-party liability adjudication rules apply.