

Bulletin Number: MSA 17-10

Distribution: Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Medicaid Health Plans

Issued: March 31, 2017

Subject: Clinic Billing Format Change to Institutional; FQHC Certification Update

Effective: July 1, 2017

Programs Affected: Medicaid, Healthy Michigan Plan, MI Child

The purpose of this bulletin is to outline changes to Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal Health Centers (THC) claim format. Utilizing the institutional format as described hereafter will align Medicaid with Medicare billing and allow for each clinic's respective encounter rate to be paid after successful adjudication for all Fee-for-Service (FFS) claims.

I. Clinic Billing Information

Effective for dates of service on or after July 1, 2017, FQHC, RHC, and THCs must use the ASC X12N 837 5010 institutional format when submitting electronic claims. Claims submitted with dates of service after this date will be denied when submitted using the professional claim format (CMS-1500 and/or 837P). Clinic dental providers must continue to use the ASC X12N 837D 5010 dental format when submitting electronic claims. Medicaid Health Plans are also expected to accept claims from the impacted clinic types on the institutional claim format beginning with dates of service on or after July 1, 2017.

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 an encounter-based payment. Procedure code coverage information is available on the Michigan Department of Health and Human Services (MDHHS) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Providers billing under the institutional format must submit all services that are rendered on the same day on one claim. FQHCs, RHCs, and THC's may submit claims that span multiple dates of service. Dates are to be adjudicated distinctly.

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 patient's medical 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.

FQHCs, RHCs, and THC's should refer to Medicare billing requirements for additional information. Refer to the Centers for Medicare and 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.

A. Revenue Codes

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

B. Clinic – 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, IPE or AWW
G0469	FQHC visit, new patient mental health
G0470	FQHC visit, established patient mental health
T1015	Clinic visit, all-inclusive (RHC use only)
59425	Antepartum care only (4-6 visits)
59426	Antepartum care only (7 or more visits)

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

C. Clinic – Qualifying Visits

Detailed HCPCS coding with the associated line item charges listing the visit that qualifies the service for an encounter-based payment and all other services furnished during the encounter are required. It is essential to document the services provided for managed care quality measures. Claims submitted with just the “Clinic – Payment Code” will be denied. Procedure code coverage information is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information. The procedure code descriptions and coverage are subject to change.

i. Claims for Medication Therapy Management

In accordance with Provider Bulletin MSA 17-09, the Billing Provider NPI reported on the claim must be the FQHC, RHC, or THC and be actively enrolled in Community the Health Automated Medicaid Processing System (CHAMPS). The Pharmacist (Type 1) NPI must be reported on the Institutional MTM claim as the Rendering Provider and must be actively enrolled in CHAMPS and associated to the Billing FQHC, RHC, or THC for the date of service. Refer to Provider Bulletin MSA 17-09 for more information on the requirements for coverage of Medication Therapy Management services.

D. FQHC – Dental APM Count

In accordance with the alternative payment methodology (APM) described in Provider Bulletin MSA 14-48, for FQHC dental claims, the dental APM will be paid when the “Clinic – APM Count” code that includes restorative services, endodontics, or extractions is billed. Limit one per beneficiary/day (modifier 59 does not apply). Payment will be listed on the first line paid.

E. Clinic – Excluded High Cost Code

If a procedure code from the “Clinic – Excluded High Cost Code” is billed, the clinic will receive the established Medicaid fee schedule rates based on the procedure codes billed. Payment will be listed on the associated code line.

F. Clinic – Excluded Technical Payments

If a code from the “Clinic – Excluded Technical Payments” is billed by a RHC, CHAMPS will pay the applicable procedure code rate. Claims must include modifier “TC.” Payment will be listed on the associated code line.

II. Clinic Reimbursement and Reconciliation

For all FFS claims, providers will receive their settlement encounter rate for reimbursement when reporting services on the institutional claim format. The encounter rate will be established using the clinic’s current prospective payment system (PPS) or Indian Health Service all-inclusive rate (AIR) methodology for provider rates. The encounter rate will be paid 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. Payment for the encounter rate will be listed on the "Clinic – Payment Code" line.

For additional information, refer to the Michigan Medicaid Provider Manual, Rate Setting and/or Encounter 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 and Forms. Rate information will be loaded into the CHAMPS Medicaid code Rate and Reference tool available under the external links.

Existing Medicare crossover and third party liability adjudication rules apply.

III. FQHC Enrollment Requirements

Each FQHC that is certified by the Health Resources and Services Administration (HRSA) and CMS to provide services as a Medicare-enrolled FQHC is eligible to apply to the MDHHS to be a Medicaid provider. FQHC school sites and stand-alone dental sites are not required to be certified by Medicare. Refer to the Medicaid Provider Manual, General Information for Providers Chapter, Provider Enrollment Section for enrollment information. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Chris Priest, Director
Medical Services Administration