

Chapter 4 : REIMBURSEMENT

BACKGROUND AND SUMMARY OF RESOURCE

In 2005, reimbursement from Medicaid and CHP+ to private practices covered less than 2/3 of the actual cost for providing care. At that time, only twenty percent of pediatric practices accepted Medicaid or CHP+ patients. Eighty-five percent of Colorado pediatricians indicated they would accept more of these children if reimbursement was closer to the actual cost of providing care, and if the other supports provided by CCHAP were available.

In response, CCHAP has worked with HCPF to develop methods to enhance reimbursement for providers:

- 1) The best list of contacts to help solve claims processing problems.
- 2) Increased Medicaid reimbursement for CCHAP practices through the Pay for Performing as a Medical Home Program.

In July of 2007, CCHAP partnered with HCPF to conduct a Medical Home Pay for Performance Demonstration Program with the 28 pediatric practices that were participating with CCHAP at that time. The program provides incentives for comprehensive preventive care for Medicaid children in all CCHAP-affiliated practices. Quality, cost and survey data from the demonstration program is being used to develop and enhance the program for all CCHAP practices, including those who joined after the initial demonstration program.

- 3) Sharing more effective methods of billing and collecting from Medicaid.

In addition to the information in this chapter, the CCHAP email newsletter contains tips on coding and billing from CCHAP practices. If have a tip that you would like to share, please send it to: poole.steven@tchden.org

CLAIMS PROCESSING PROBLEMS

CONTACTS

CCHAP has worked with the Colorado Department of Health Care Policy and Financing (HCPF) to identify the right people to help with the specific problems with Medicaid and CHP+. Their names and contact information are listed below:

Medicaid Provider Services:

Phone (303) 534-0146 or (800) 237-0757

<http://www.colorado.gov/hcpf>

- Claims and prior authorization submission
- Claims and status inquiries
- Claims verification
- Provider Demographic Updates

Medicaid Customer Service: (303) 866-3513 or 1-800-221-3943

Medicaid Pharmacy Questions: (800) 365-4944

Denver Health Prior Authorizations:

When you check eligibility and find one of your patients has been enrolled into Denver Health, you will need to call the following people at the Denver Health Referral Center and attempt to get a pre-authorization to see the patient, prior to seeing the patient. Please refer to Chapter 3 for more detailed information regarding Passive Enrollment issues.

Cecilia Fink at (720) 956-2340

Linda Spaulding at (720) 956-2206

Karen Dillon at (720) 956-2211

CHP+ prior Authorizations - Shelley Tracy (720) 956-2358

Child Health Plan Plus (CHP+):

ACS/CHP+ Main Office – determines eligibility

www.cchp.org

600 17th #710, Denver, CO 80202

CHP+ Customer Service: (800) 359-1991

Fax (303) 893-1780

Customer Service Manager: Rebecca Schreiber (303) 866-3877

rebecca.schreiber@state.co.us

CHP+ Colorado Access:

www.coaccess.com

Customer Service and Provider Service: (303) 751-9005 or (800) 511-5010

PNS@coaccess.com

Claims:

PO Box 17470

Denver, CO 80217-0470

MAXIMIZING STRAIGHT MEDICAID REIMBURSEMENT

Health Maintenance for Young Children

We are learning new methods for appropriately enhancing reimbursement for health maintenance care for younger children. It is now possible to receive a reimbursement for health maintenance visits for Medicaid children that is competitive with the reimbursement that is received from the commercial health plans.

The new Medicaid reimbursement rates provide incentives for preventive care and developmental screenings for young children.

| | |
|---|---------|
| 99391 infant visit | \$66.56 |
| 99392 1-4 year old visit | \$74.55 |
| Administration of each injection - | \$6.38 |
| (The vaccine is provided free through VFC. Please note, however, that you <i>must</i> bill for both the vaccine and the administration in order to be reimbursed the \$6.50) | |
| 96110 Developmental screening - | \$36.10 |
| (requires documentation of the developmental test performed; ASQ is the preferred screening tool) | |

So, for example, a 4 month old Medicaid Well Child Visit with 4 injections:

| | |
|---------------------------------|----------|
| 99391 visit - | \$66.56 |
| 90700 injection - | \$6.38 |
| 90648 injection - | \$6.38 |
| 90713 injection - | \$6.38 |
| 90669 injection - | \$6.38 |
| 96110 developmental screening - | \$36.10 |
| Total - | \$128.18 |

Comparison of Medicaid reimbursement with commercial health insurance

| | 99391-visit | 4 injections | Developmental screening | Total |
|------------------------------|-------------|--------------|-------------------------|-------|
| Medicaid | \$67 | \$26 | \$36 | \$128 |
| Average Commercial Insurance | \$103 | NA* | \$17 | \$120 |

*When comparing immunization reimbursement – the question is whether the commercial health insurance company reimbursement for each immunization exceeds the practice cost. If so, that is compared with the \$6.38 injection fee paid by Medicaid.

For a 4-year-old who receives 4 injections and developmental screening, the total Medicaid payment is about \$128, compared to the average commercial reimbursement of \$120. And remember, the vaccine for Medicaid children is free.

Medicaid Reimbursement for Developmental Screening

HCPF encourages you to perform an approved, standardized, developmental screening on children through age 5, and bill CPT code 96110 at the \$36.10 allowable amount when appropriate. The developmental screening code does replace the 99173 Vision Screening (Titmus, Illiterate E) and 92551 Hearing Screening codes. Please refer to Chapter 11 for more information about developmental screening.

It was brought to our attention that Medicaid was not paying the allowable amount for some charges. Medicaid pays whichever is least, between your charge and the allowable. Check to make sure you are billing at the maximum allowable for each code used.

MAXIMIZING REIMBURSEMENT FOR CARE PROVIDED TO MEDICAID CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

Individual Healthcare Plan 99215 = \$104.87

An Individual Care Plan is a standardized summary of the child's pertinent health record that the family greatly appreciates having available in times of need. It can help improve care, expedite treatments, reduce errors and medico-legal risk, and improve communication.

Examples of use:

- they see any of the child's specialists
- they go to an emergency department or urgent care center
- they are traveling
- the child is admitted to a hospital
- paramedics are called to the school
- an insurance company requests a case summary to authorize claims payment or referral,
- a school requests health information.

The 4-page Universal Care Plan can be filled out in a visit with the parents, with or without the patient present. A copy of the Universal Care Plan can be downloaded from our website <http://www.cchap.org/information-library/tools-to-help-in-the-care-of-special-needs-children/>. The CPT code 99215 can be billed for the time it takes to complete the document. This code is good for up to 45 minutes, and typically takes 20-30 minutes to complete the first time and then 10-15 minutes to update thereafter.

First visits for a CYSHCN 99204 = \$119.37

On the initial appointment, you can bill a comprehensive exam and with adequate documentation, you can bill at the moderate complexity rate.

Annual Health Maintenance Visit

As you know, CYSHCN and their parents often miss out on anticipatory guidance and standard health maintenance issues because the provider is working with the patients multiple ongoing conditions. Be sure to schedule a health maintenance visit with the patient to discuss developmentally age-appropriate guidance. Reimbursement from Medicaid is equal to that of commercial insurances for developmental assessment of a patient that is 0-5 with CSHCN.

MEDICAID REIMBURSEMENT FOR TREATING BEHAVIORAL PROBLEMS IN YOUR PRACTICE

You can be reimbursed by Medicaid for counseling Medicaid parents and/or children for mental health issues or behavioral problems, but only if it is coded and billed correctly.

As you know, for billing there are two types of codes:

1. Diagnosis Codes (ICD-9 codes)- which are divided into
 - a. Physical (medical) health diagnoses
 - b. Mental health diagnosis

2. Visit or Procedures Codes – CPT codes- which are divided into:
 - a. Medical visit codes
 - Preventative care visits/procedures
 - E and M codes for illness care visits
 - b. Mental health visit codes
 - Counseling codes
 - Psychotherapy codes

The points to remember for Medicaid mental health billing by primary care providers are:

1. Use the appropriate ICD-9 mental health diagnosis code
2. Use only physical health (medical) CPT visit codes, not mental health visit codes (NO counseling codes)

CPT Coding for Behavioral Problems

Your Medicaid contract is for a physical health (medical) provider, not a mental health provider. If you code your visit with a mental health or counseling visit you will be denied payment. You can bill medical E and M code (i.e. 99213, 99214, and 99215) using the length of the visit or the supporting elements of the visit. You must document either the length of time (and that greater than 50% of the time was spent in counseling or care coordination) or the key elements that make the diagnoses. This process also works for the way you would bill commercial health plans. Counseling for this purpose is defined not as psychotherapy but as:

“a discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies, prognosis, risk and benefits of management (treatment) options, instruction for management and/or follow-up, importance of compliance with chosen management, risk factor reduction, patient and family education”.

The time elements for the actual amount of time counseling are as follows:

| | |
|----------------------------|----------------------------|
| 99212 = 10 minutes minimum | 99201 = 10 minutes minimum |
| 99213 = 15 minutes minimum | 99202 = 20 minutes minimum |
| 99214 = 25 minutes minimum | 99203 = 30 minutes minimum |
| 99215 = 40 minutes minimum | 99204 = 45 minutes minimum |
| | 99205 = 60 minutes minimum |

ICD-9 Codes

You can use the appropriate mental health diagnosis on the bill. If you cannot find an appropriate diagnosis (like depression, anxiety, ADHD, etc.) consider: behavioral disturbance NOS.

Examples:

Case 1: A mother brings in her autistic 5 year old for advice regarding how to manage the behavioral problems and discipline. You spend 20 minutes giving her the requested advice.

Billing: CPT code 99214 based on documentation of appropriate elements. If you are only giving advice (no exam), billing should be coded based solely on time, which would be a 99213.

ICD-9 coding: Use the mental health condition as the primary diagnosis (behavioral disturbances NOS) and autism (299.00) as the secondary diagnosis for Medicaid.

Case 2: An 8 year old child is in for a health maintenance visit. Towards the end of the visit the mother says that the child's school wants him evaluated for ADHD. You spend an extra 15 minutes addressing the ADHD.

Billing: CPT codes: There are two options: (1) bill as a 99215 if you include all elements in the note. (2) bill both (a) 99393 for the health maintenance and (b) 99213 for the ADHD evaluation. A representative from Medicaid has told us they will pay in this instance. For commercial payors, you need to include the -25 modifier, but with Medicaid you do not.

ICD-9 codes: (1) V20.2 preventative care and (2) 314.0 for ADHD

Case 3: If a child comes in with an ear infection, but the conversation deviates to problems at school and other behavior issues and the visit ends up taking 41 minutes, you would bill CPT 99213 (for the Otis media), and the prolonged physician service code 99354 for the additional 31 plus minutes spent talking about the behavioral problems. You need to document the basics of what was discussed. The ICD-9 codes would be 382.00 and the behavioral codes. This requires only one encounter and more than doubles reimbursement.

MEDICAID PRIOR AUTHORIZATIONS

FFS Prior Authorization Requirements

Under FFS reimbursement, the Colorado Medical Assistance Program prior authorizes:

- Expensive services such as transplantation, long term care, most DME, Orthodontia, hearing aids, PDN and OT and PT
- Procedures where inappropriate utilization has been reported in medical literature.
- Procedures that may be performed both for medical reasons and for cosmetic reasons.

FFS prior authorization approval assures the provider that the service is medically necessary and a Colorado Medical Assistance Program benefit.

- Approval of the Prior Authorization Request (PAR) does not guarantee Colorado Medical Assistance Program payment.
- PAR approval does not serve as a timely filing waiver.
- PAR approval does not override benefit eligibility requirements or benefit delivery requirements.

PAR Forms:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696550>

Pharmacy PAR Form:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132>

Pharmacy Preferred Drug List:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609>

Please refer to the General Provider Information Manual and other related billing guides on the HCPF website for additional details regarding PARs:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542320888>

TOP 10 REASONS A PAR WILL DENY

1. Duplicate
2. Missing or Invalid Provider (billing or requesting) number
3. Incomplete questionnaire
4. Dates of service
5. Over three months (timely)
6. No number of requested units
7. Invalid DOB or Client ID
8. Invalid code
9. Information provided does not meet the guidelines of medical necessity
10. Not a benefit

Please be aware that with some PARs, a letter of medical necessity is required.

Writing the Letter of Medical Necessity

1. Name of child, names of parents (parents and child may have different names)
2. Date of birth of child
3. Insurance plan name (there may be more than one plan)
4. Relevant diagnoses (codes are helpful only if they are accurate!)
5. Item/service requested
6. Why item/service is medically necessary (refer to the plans' definition)
7. What positive/negative impacts the item/service will result on (include financial)
8. Scope and duration of treatment
9. Supplemental documents (letters from other providers, research articles, product information, PAR, results from the well child exam, etc.)
10. Funding streams NOT able to help
11. Terms to use
 - a. medically necessary
 - b. clinically based
 - c. promoting independence
 - d. preventing secondary disability
 - e. cost-effective
 - f. safety
12. Terms to avoid
 - a. custodial
 - b. rehabilitate
 - c. developmental delay/disability
 - d. speech delay (without a diagnoses such as aphasia)

PARs should be submitted to:

Prior Authorization Request
PO Box 30
Denver CO 80201-0030

For assistance with PARs and Letters of Medical Necessity:

303-534-0279
1-800-237-7647

PAR Hotline for Medical Home Providers:

DME Line: (303) 866-5571

Find out what was approved, what was denied and research questions the providers or the parents may have about why something was denied.

All Other PARS: 1-866-956-9409

Find out if a PAR is in process or already denied or approved. Also provides help with the denial reasons. This line should be limited to providers only. Parents can call the other line for DME.

PAY FOR PERFORMING AS A MEDICAL HOME

Objective

The Colorado Department of Health Care Policy and Financing (HCPF) and CCHAP are working together with private pediatric and family practice offices affiliated with CCHAP to implement and evaluate a program that:

- Increases reimbursement for practices that provide a good medical home for Medicaid children and rewards practices for providing comprehensive preventive care for Medicaid children
- Will generate information regarding the impact of a private practice medical home on health outcomes of Medicaid children
- Will generate information for HCPF to use in making future decisions about reimbursement (and pay-for-performance programs) for private practices.

What your practice will need to agree to:

- You will provide a medical home for your Medicaid children as you do for all your patients, consistent with the American Academy of Pediatrics definition.
- You will also need to arrange for your practice and your patients to complete a short survey, the Medical Home Index. This will help you assess how your practice is providing the various elements of a medical home.
- You will implement a Quality Improvement plan (or submit documentation of an existing QI project) that relates to at least one of the Medical Home Standards.
- You will provide preventive care visits meeting the recommendations of the EPSDT periodicity schedule:
 - 10 visits in the first 2 years
 - One visit annually thereafter
 - Arrange for Lead Screening between 1 and 2 years of age. Most daycare facilities and Head Start require verification that this has been done.
 - Perform a developmental screening using an approved, standardized tool, (and bill for it using code 96110) at 12 months, 18 months and 24 months *at a minimum*; or follow the ABCD recommendations.

How it will work: Practices will receive pay for performance for the preventive care codes than other practices for their Medicaid children. In the table below, you will see the usual Medicaid rates, the additional rate and the resultant total reimbursement.

Note: Also see a more detailed analysis of preventive medicine reimbursement rates on page 4-12.

| Code | Service | Medicaid Payment as of 7/1/2010 | Additional Medical Home Incentive | Total |
|--------------------------------|-----------------------------------|---------------------------------|-----------------------------------|---------------|
| Preventative Medicine Services | | | | |
| 99381 | New patient, under 1 year | \$77.68 | \$10 | \$87.68 |
| 99382 | New patient, 1 - 4 years | \$83.97 | \$10 | \$93.97 |
| 99383 | New patient, 5-11 years | \$82.65 | \$40 | \$122.65 |
| 99384 | New patient, 12-17 years | \$89.91 | \$40 | \$129.91 |
| 99385 | New patient, 18-39 years | \$89.91 | \$40 | \$129.91 |
| 99391 | Established patient, < 1 year | \$66.56 | \$10 | \$76.56 |
| 99392 | Established patient, 1-4 years | \$74.55 | \$10 | \$84.55 |
| 99393 | Established patient, 5-11 years | \$68.74 | \$40 | \$108.74 |
| 99394 | Established patient, 12-17 years | \$75.36 | \$40 | \$115.36 |
| 99395 | Estab. patient, 18 up to 19 years | \$76.03 | \$40 | \$116.03 |
| 96110 | Developmental screening | \$36.10 | N/A | \$36.10 |
| 99460/99461 | Newborn Care | \$55.62/70.52 | \$10 | \$65.62/80.52 |

You will bill Medicaid as you normally do for your Medicaid patients, and you will be paid at the higher rate. You do not need to add a modifier.

Medicaid pays whichever amount is least between (1) your practice's charge and (2) the Medicaid allowable. Please charge at least the current Medicaid allowable as shown in the table above. Some practices have been charging less than the Medicaid allowable, and are only receiving that amount. *When you bill Medicaid, bill the max amount. You will get the max that Medicaid pays plus the incentive fee. DON'T under bill Medicaid.*

Use code 96110 to bill for your developmental screening of all children up to 6 years if you are using an approved, standardized screening tool. This is recommended by Medicaid, and is reimbursed at \$36.10 (see Chapter 11). We suggest you consider adding this code to your super bill.

Vision and Hearing: Hearing and vision screening is an expected part of a well child check-up and bundled with the well visit code. So, if you bill for this service as a separate line item on the same claim as the well visit, you will not be reimbursed. If you do these at a sick visit, however, you will get reimbursed for them in addition to the E&M code. Strange but true.

Program Evaluation

The program will be evaluated at 6, 9, and 12 months to review the budget and to evaluate its effectiveness. Outcomes that will be tracked by HCPF and CCHAP are:

- Ratio of preventive visits to expected (10 visits by 2, 1 every year after)
- ED utilization rates
- Immunization rates
- Parent satisfaction
- Use of Preventative Screening Tool (96110)
- Willingness to take more Medicaid kids