LHD Billing FAQ

99211

- 99211 (often called a “nurse visit”) cannot be billed unless the client has been established in your clinic by a mid-level practitioner or higher (NP, PA, MD)
    - 99201 and up are the codes you use to establish a client in your clinic

        - **For new patients:**

        - 99201 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

        - 99202 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

        - 99203 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

        - **For Established Patients:**

        - 99211 (also known as a “nurse visit”) - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the

presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

- 99212 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

- 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

- See the following page for elements of office examinations

Level of Exam	Perform and Document
Problem Focused	One to five elements identified by a bullet
Expanded Problem Focused	At least six elements identified by a bullet
Detailed	At least twelve elements identified by a bullet
Comprehensive	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

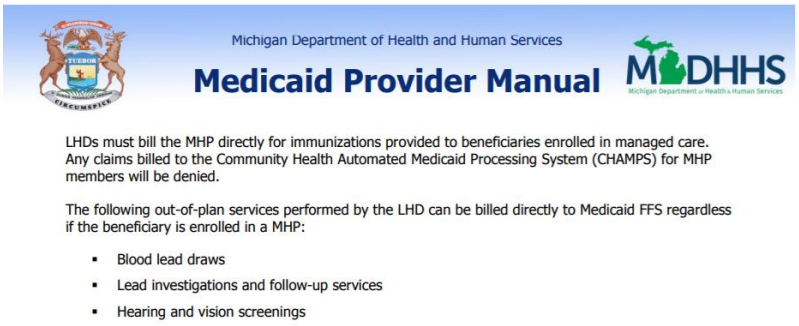
Respiratory Examination	
System/Body Area	**Elements of Examination**
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff). • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	• Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass) • Examination of jugular veins (e.g., dissension; a, v or cannon a waves)
Respiratory	• Inspection of chest with notation of symmetry and expansion • Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
Respiratory (continued)	• Percussion of chest (e.g., dullness, flatness, hyperresonance) • Palpation of chest (e.g., tactile fremitus) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location.
Musculoskeletal	• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements • Examination of gait and station
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)

Neurological/ Psychiatric	• Brief assessment of mental status including:
	  • orientation to time, place and person
	  • mood and affect (e.g., depression, anxiety, agitation)

<u>Hearing & Vision</u>

- CPT Codes are
- DX codes used is generally Z13.5 as this is a screening code
    - Some LHDs use Z00.129 which is a “pay & chase” code that will pay regardless of other insurance

    - It is ok to bill that if you have proper documentation that determines that is the right code, but it is not appropriate to use it just to bypass TPL
- Use place of service 3 for school and 71 if performed at the LHD
- According to the Medicaid Provider manual LHDs may bill hearing & vision screens to FFS Medicaid regardless if the client has a health plan



Michigan Department of Health and Human Services

Medicaid Provider Manual

MDHHS

LHDs must bill the MHP directly for immunizations provided to beneficiaries enrolled in managed care. Any claims billed to the Community Health Automated Medicaid Processing System (CHAMPS) for MHP members will be denied.

The following out-of-plan services performed by the LHD can be billed directly to Medicaid FFS regardless if the beneficiary is enrolled in a MHP:

- Blood lead draws
- Lead investigations and follow-up services
- Hearing and vision screenings

PCG Billing Issues

- LHDs have been dealing with issues with PCG for well over a year. They are billing LHDs for clients who have insurance even though LHDs have provided them (usually multiple times) with their insurance information
- LHDs have received large bills and threats of being sent to collections
- The admin forum is involved and has been escalated to MDHHS administration
- For now LHDs will still need to continue reaching out to PCG on their own to work out the issues

Free Care Rule

- MSA 17-21 was not intended to prevent LHDs for billing for services such as hemoglobins and hearing & vision screens
- Per Craig Boyce in policy MDHHS legal is looking in to this issue as of 7/9/18

VFC Admin Fees

- According to the document "VFC ELIGIBILITY – WHO CAN RECEIVE VFC VACCINES" you must bill Medicaid for the admin fee if you use VFC stock. If you want to bill their primary health plan you must use private stock and bill their insurance.
    - "Occasionally, children may be VFC-eligible for more than one eligibility category. A provider must select and document the eligibility category that will require the least amount of out of pocket expense to the parent/guardian for the child to receive necessary immunizations. When vaccinating a child who presents with dual insurance coverage – both Medicaid and private insurance – you must choose to either vaccinate with VFC vaccine, bill Medicaid for the administration fee and record the child as Medicaid in MCIR OR use private stock vaccine, bill the private insurance company for the vaccine and the administration fee and record child as fully insured in MCIR. You

cannot use VFC vaccine and bill the private insurance company for the administration fee. It's one or the other – not a combination of both" (As of 6/227/18)

Lead

- If you are having trouble getting paid for blood lead draws (36416) and do not bill for the actual lead test, you can bill FFS Medicaid for this procedure even if the client has a health plan
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