MDH Billing Manual Frequently Asked Questions

Send questions regarding the MDH Billing Manual or questions related to the Billing Manual Topics to:
MarylandLHDBM@rsandf.com

This information is provided by RS & F and does not represent official guidance from MDH.

Billing Manual Section	Topic	Question	Answer	Resource
RCM	Coding/ Reimbursement	**Who can be the rendering provider in a Behavioral Health setting, MD, NP, and CSW?**	Incident To Services are covered for both Medical and BH services, if the services are:1) An integral, although incidental, part of the physician's professional service 2)Commonly rendered without charge or included in the physician's bill 3) Of a type that are commonly furnished in physician's offices or clinics 4)Furnished by the physician or by auxiliary personnel under the physician's direct supervision . In the BH practice setting outpatient psychiatric services furnished as 'incident to' professional services are limited to the following: Physician, Cinical Psychologist, Nurse Practitioner, Clinical Nurse Specialist, Phyician Assistant, Clinical Social Worker, Certified Nurse Midwives.	https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00150921
RCM	Coding/ Reimbursement	**Is the rendering provider required to complete all New Intakes?**	Per Medicare guidelines: Incident To Services requires the "Initial Encounter" to be performed by the rendering provider. The rendering provider MUST set the Plan of Treatment for the patient. The rendering provider MUST see the patient for any new issues and MUST approved and changes or updated to an existing plan of treatment	https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00004947

RCM	Coding/ Reimbursement	**How often does the rendering provider need to re-evaluate a patient when billing as "incident to"?**	Unfortunately, there is no specific guidelines on how often the rendering provider needs to re-evaluate the patient. Medicare states – "*It is expected that the physician performs subsequent services of a frequency that reflect that active participation of the course of treatment for the specific problem.*"	https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00150920
RCM	Coding/ Reimbursement	**What must be included on the treatment plan?**	There are no specific guidelines regarding treatment plans. In general, the course of treatment just needs to be specifically documented, not inferred – Patient F/U instructions, Medications and dosages, F/U visits, plans or expectations for next visit.BH / Counseling Treatment Plans may include, but not limited to the following: •Patient diagnosis •Patient status •Treatment options •Goals •Additional types of therapy •Order/Review of diagnostic testing	
Compliance	No Surprise Act	**How does the No Surprise Act affect LHD when most of this seems to be hospital related?**	BH / Counseling Treatment Plans may include, but not limited to the following:	• https://insurance.maryland.gov/Consumer/Pages/Federal-No-Surprises-Act.aspx • https://www.cms.gov/nosurprises
RCM	Coding/ Reimbursement	**Does Incident to billing regulations apply to midlevel providers who are billing Mediare and does not include Medicaid?**	Patient diagnosis	https://health.maryland.gov/mmcp/Documents/2021%20Professional%20Services%20Provider%20Manual%20website.pdf

RCM	Coding/ Reimbursement	**Can you bill nursing services related to incident to billing?**	Patient status	***Mid-Level billing matrix will be upload in V38 of the billing manual.** Slide deck has been uploaded your reference. https://health.maryland.gov/pophealth/Documents/Local%20Health%20Department%20Billing%20Manual/5.18.22-LHD-Billing-Manual-Webinar-PPT.pdf
Telehealth	Coding/ Reimbursement	**Multiple payers are denying claims with CPT code 99443 (Telephone E/M service 21-30 minutes). Is this code no longer a covered service?**	Treatment options	•April2020 Telehealth Program Manual.pdf (maryland.gov) •https://health.maryland.gov/mmcp/SiteAssets/SitePages/Telehealth/April2020%20Telehealth%20Program%20Manual.pdf •Telehealth Services (cms.gov) •COVID-19 Telemedicine Coverage FAQs for Aetna Providers
COVID	Vaccine /Coding	**For the second booster doses, will there be a new separate billing code or should the current booster codes (Pfizer: 0004A, etc.) be used for all current and future recommended booster doses?**	Goals	https://www.ama-assn.org/find-covid-19-vaccine-codes 2022-04-14-MLNC | CMS
COVID	Coding	**What diagnosis codes should we use for Rapid PCR COVID tests, Flu A & B, and RSV testing?**	Additional types of therapy	https://www.ama-assn.org/find-covid-19-vaccine-codes

Compliance	HIPAA	**How often is our practice required to perform a Security Risk Assessment (SRA)**	Order/Review of diagnostic testing	https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool https://www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html
RCM	Coding	**Has CPT code 99211 been deleted for 2022?**	No, 99211 is still a valid CPTcode for 2022.	
Behavioral Heath	Coding	**Are there any Behavioral Health CPT code updates for 2022?**	There are no changes to the core Behavioral Health CPT codes for 2022. However, remote therapeuticmonitoring codes 98975-98977 and 98980-98981 have been added for 2022.	https://www.ama-assn.org/practice-management/cpt
RCM/ Telehealth	Place of Service	**Are there Place of Service (POS) changes for Telehealth in 2022?**	Effective January 1, 2022 to meet the changes to Telehealth, Medicare is updating the descriptions for POS 02 and creating POS 10. You can find the publication at the following website. Please refer to Commercial payer websites for their updates.	https://www.cms.gov/files/document/mm12427-newmodifications-place-service-pos-codes-telehealth.pdf

COVID / RCM	Modifier	**Do you recommend adding a CS modifier to COVID codes?**	Many carriers have specific instructions on when and how to utilize the CS modifier for cost sharing. I recommend reviewing payor websites for specific cost-sharing information and modifier use.	
RCM	Coding	**Are we able to bill patients/insurance for chart audits? Is so, can we use 99211?**	NO, you cannot bill for chart audits. Chart audits are done to help physicians identify areas of improvement and review documentation and coding compliance. These tasks are not billable to insurances or the patient. The CPT definition of a 99211 service is - 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. Chart audits or documentation reviews are not supported by CPT code 99211.	www.ama-assn.org
IV	Immunizations/ VFC	**If I bill a VFC vaccine administration fee to Medicaid or a Medicaid MCO, do I have to charge uninsured or underinsured patients a vaccine administration fee?**	Yes, however, if the uninsured patient does not have the ability to pay the vaccine administration fee, the vaccine must be provided and the administration fee must be waived.	
COVID / III	COVID Billing	**Is there a code for the J&J COVID booster?**	AMA assigned code **0034A** to the COVID-19 vaccine booster dose from Janssen. The code is as follows: 0034A: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5 mL dosage; booster dose	https://www.ama-assn.org/find-covid-19-vaccine-codes

COVID / III	COVID Billing	**Do you have coding information for the COVID boosters? Do the codes differ per manufacturer?**	Yes - the AMA has updated CPT does for the new COVID vaccine boosters. Both the vaccine and administration codes are specific to the manufacturer.	• https://www.ama-assn.org/find-covid-19-vaccine-codes • https://www.ama-assn.org/system/files/covid-vaccine-medium-descriptors.pdf
III/ IV	Billing	**Are Telephone Services covered by all payors?**	Unfortunately, not all payers cover telephone services 99421 – 99423. Maryland Medicaid does not cover these services and most of the Maryland Medicaid MCOs follow the MD MA guidelines. CareFirst will cover 99441-99443 for a flat fee of $20.00. They do not cover this service for Specialist. I recommend checking each payor website for more details.	
III/ IV	Non-chargeables	**What defines the non-chargeable service items?**	Each year the Maryland Dept. Health determines the Non-Chargeable List. The non-chargeable list is agreed upon by all of the health officers. I have attached the FY21 Non-chargeable list for your records.	https://health.maryland.gov/pophealth/Documents/Local%20Health%20Department%20Billing%20Manual/PDF%20Manual/Section%20III/FY20%20Non-Chargeable%20Service%20List.pdf

III	Billing / Collections	**Can we send eligible patients to CCU? Are CCU account on hold due to COVID?**	On April 6, 2020 a notice was sent to all CCU creditors advising of the Governor's Mandate to cease collection efforts. ***Effective 10/9/20, CCU was given approval to resume full collection activity and distributed the message below.***	https://www.marylandattorneygeneral.gov/Pages/COVID19/050120_Advisory.pdf
III / IX	Billing / Resources	**Where do I find more information on the meanings of the denial codes?**	In Section IX – Resources, there is information regarding adjustment codes. You can also find information at the Novitas Solutions and WPC websites.	• http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/Claim • https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00004554
VI	Maryland Payers / Medicaid MCO	**Does the Unv of MD MCO still exist?**	CareFirst has acquired 2 University of Maryland Medical System Health Plans. The networks will remain separate. Your contract with UM Health Partners/UM Health Advantage will remain the same. Effective February 1, 2021 both plan names will change. UM Health Partners will be known as CareFirst BlueCross BlueShield Community Health Plan Maryland and UM Health Advantage will be known as CareFirst BlueCross BlueShield Medicare Advantage.	https://www.umms.org/news/2020/carefirst-umms-unveil-partnership-drive-innovative-healthcare-statewide • https://www.umhealthpartners.com

COVID / III	COVID Billing	**Can 99211 be billed for a new patient if a nurse/ma collects a COVID-19 specimen?**	CMS has expanded the use of 99211 during the COVID 19 crisis. This was documented in the CMS Interim Final Rule on April 30. Payment for COVID-19 Specimen Collection: In the IFR, CMS clarifies that it will allow use of CPT code 99211 (Level 1 established patient office/outpatient E/M visit) for COVID-19 assessment and specimen collection by a physician, qualified health care professional or clinical staff for new or established patients for the duration of the PHE. CMS notes in the rule that the direct supervision requirements for services performed by clinical staff "incident to" a physician's service can also be met through use of interactive audio and video telehealth technology. CMS also finalized coverage of FDA-authorized COVID-19 serology (antibody) tests on an interim basis.	https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf
IV	Immunizations	**Is it required that all LHDs bill/charge for immunization services?**	Yes, According to COMAR regulations 10.02.01.01 .01 Purpose - It is the intent of these regulations that: A. Charges for health services reflect the full costs of rendering those services; B. There be a single charge for each service rendered in each unit; C. The methods for determining full costs be uniform among all units." The only exception is items listed on the non-chargeable list. - **The regulations do not require the LHD has to bill the payer(s) ** EXAMPLE: Emergency Preparedness – Screening for and administration of immunizations for traditional and other emergency responders during a local or state public health emergency event.	http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.02.01.*

IV	HIV / PrEP	**Clients in the PrEP program are required to have STI testing every three months. We use ICD-10 codes Z11.3 and 272.52. But BCBS will only pay for testing one time a year. LabCorp suggested that when we send the orders to them, that we code as medical necessity in order to get the insurance to pay for testing the rest of the year. How do we code for medical necessity?**	Each commercial payer has different guidelines. Most commercial payers will only pay for testing with screening diagnoses once a year. So to reduce the chance of denial or uncovered service, you may consider using ICD-10 codes that describe the reason the patient is receiving PrEP services. EXAMPLE: • High Risk Sexual Behavior: o Heterosexual – Z72.51 o Bisexual – Z72.53 o Homosexual – Z72.52 • Contact or Exposure to: o Sexually Transmitted Disease – Z20.2 o HIV (AIDS) – Z20.6 There may be other acceptable diagnosis codes, these are a few examples. You will have to call each payer specifically to determine what they deem “medically necessary” to cover PrEP testing.	