

Module 2: Billing Requirements

Module 2: Billing Requirements

Training Objectives

Participants will:

- Understand the Free Care and Other Health Coverage (OHC) requirements
- Identify when services are not reimbursable due to Free Care limitations
- Understand the general billing code structure for LEA services
- Understand and identify common billing mistakes

Module 2: Billing Requirements

Overview

- Section 1 – Free Care Provision
- Section 2 – State Mandated Assessments
- Section 3 – Other Health Coverage/
Third Party Liability
- Section 4 – Overview of Billing Code Structure

Module 2: Billing Requirements

Section 1: Free Care Provision

Module 2: Billing Requirements

Free Care Provision - Principle

- General Principle: LEAs cannot bill Medi-Cal if the same service is offered to non-Medi-Cal beneficiaries without charge
- Exceptions to the Free Care Principle:
 - Medi-Cal covered services provided under an IEP/ IFSP
 - *However*, for those services exempt from the free care requirement, the LEA provider still must pursue any other health coverage (OHC) for reimbursement before billing Medi-Cal

Provider Manual Reference: loc ed bil

Module 2: Billing Requirements

Free Care Provision - Policy and Requirements

- In order to bill Medi-Cal for Free Care services, LEAs must do all of the following:
 - Establish a fee for each service provided
 - Collect and bill OHC information from 100% of the population served
 - Bill other responsible third party insurers (OHC) before billing Medi-Cal
- If any parent refuses to allow OHC to be billed, and the LEA service is still provided, it is considered Free Care and the LEA may not bill Medi-Cal for that type of service to any student

Provider Manual Reference: loc ed bil

Module 2: Billing Requirements

Free Care Provision - FAQ #1

Example: A school nurse conducts a diabetes/ obesity screening to a pre-selected, at-risk student population. Can this screening be billed to Medi-Cal?

NO

This service is being provided to the entire at-risk population free of charge. In order to bill Medi-Cal for the service the LEA would have to gather OHC information for 100% of the population served, bill OHC prior to billing Medi-Cal, and establish a fee for this service

Module 2: Billing Requirements

Free Care Provision - FAQ #2

Example: A child without an IEP receives an assessment for a speech disorder. The LEA has OHC information on every student, and has developed a fee for this assessment, based on a sliding scale. This child has no OHC. Can this assessment be billed to Medi-Cal?

YES

The LEA has met all Free Care requirements and the service may be billed to Medi-Cal.

Module 2: Billing Requirements

Free Care Provision - FAQ #3

Example: A child without an IEP receives health education/anticipatory guidance. This child has OHC. The LEA has OHC information on a few students, but not all. Can this assessment be billed to Medi-Cal?

NO

This service may not be billed to Medi-Cal because the LEA has not fulfilled all Free Care requirements. The LEA has not established 100% OHC information for all students nor have they first billed the child's OHC.

Module 2: Billing Requirements

Free Care Provision - FAQ #4

Example: A child receives physical therapy treatment twice a week per his IFSP. This child does not have OHC. Can this LEA bill this treatment directly to Medi-Cal?

YES

The LEA may bill Medi-Cal directly, since the student has no OHC and the service is pursuant to the IFSP.

Module 2: Billing Requirements

Section 2: State Mandated Assessments

Module 2: Billing Requirements

State Mandated Assessments

- LEAs are legally obligated to provide and pay for services that are mandated by State law, such as State mandated screenings
- Services provided by LEAs that are mandated by State law are not reimbursable and may not be billed to Medi-Cal

Provider Manual Reference: loc ed bil

Module 2: Billing Requirements

State Mandated Assessments - FAQ #1

Example: An IEP child receives a non-IEP assessment that is mandated by State law. Can this be billed to Medi-Cal?

NO

State mandated assessments may not be billed to Medi-Cal since they are provided to all students free of charge.

Module 2: Billing Requirements

State Mandated Assessments - FAQ #2

Example: A child is referred by a teacher for a vision assessment (outside the mandated periodicity schedule) because he may not be seeing the blackboard clearly. The LEA has OHC information on every student, and has developed a fee for this assessment. This child has no OHC. Can this assessment be billed to Medi-Cal?

YES

The LEA may bill Medi-Cal since the service was conducted outside of the State mandated periodicity schedule and the LEA has met all Free Care requirements.

Module 2: Billing Requirements

Section 3: Other Health Coverage (OHC)/Third Party Liability (TPL)

Module 2: Billing Requirements

OHC/TPL - Principle

- General Principle: Medi-Cal will not pay for services if another third party is legally liable and responsible for paying for the services
- If a student has OHC, the provider must bill the other insurer or obtain documentation that the plan does not provide coverage for the specific service rendered before billing Medi-Cal

Provider Manual Reference: loc ed bil

Module 2: Billing Requirements

OHC/TPL - Documenting Non-Coverage

- How do we document that the student's OHC does not provide coverage for the specific service rendered before billing Medi-Cal?
 - Bill the other health plan using proper billing procedures and receive a claim denial for the specific service rendered.
 - The claim denial is valid for one year. Examples of legitimate denial reasons are: service not covered, patient not covered, deductible not met, etc.
- LEAs are responsible for documenting non-coverage

Module 2: Billing Requirements

OHC/TPL - Managed Care

- LEAs may be reimbursed for services provided to students in a Managed Care Plan (MCP)
 - Services must be in the student's IEP/IFSP
 - Services not in the student's IEP/IFSP are subject to annual service limitations

Provider Manual Reference: loc ed bil

Module 2: Billing Requirements

Section 4: Overview of Billing Code Structure

Module 2: Billing Requirements

Billing Structure - Data Requirements

- Claim form submission requirements:
 - Medi-Cal Recipient Name
 - BIC Number
 - Date of Birth
 - Date of Service
 - Procedure Code and Modifier(s)
 - ICD-9 Diagnosis Code
 - Number of Units
 - Provider Name (LEA District or COE)
 - NPI Billing ID

Module 2: Billing Requirements

Billing Structure - Code Overview

CPT-4 / HCPCS

Procedure Code

(5 digit code)

+

Modifier(s)

(2 digit code)

- Identifies LEA service:

- Assessments
- Treatments
- Transportation
- Targeted Case Management

- When applicable, identifies service type:

- IEP or IFSP
- Practitioner type
- Intensity of service

Provider Manual Reference: loc ed bil

Module 2: Billing Requirements

Billing Structure - Assessment Example

IFSP Amended Speech-Language Assessment

Procedure Code

Modifiers

92506

TS

GN

TL

LEA Service:

**Intensity
of Service:**

Practitioner:

**IEP/IFSP
Services:**

Speech Assessment

Amended

Speech-Language
Pathologist

IFSP

Note: Modifiers may be in any order on the claim

Provider Manual Reference: loc ed serv spe

Module 2: Billing Requirements

Billing Structure - Treatment Example

IEP Individual Psychology/Counseling
Additional Treatment by a Social Worker

Procedure Code

Modifiers

96152

22

AJ

TM

LEA Service:

Individual
Psychology
Counseling

**Intensity
of Service:**

Additional
15-Minutes

Practitioner:

Social Worker

**IEP/IFSP
Services:**

IEP

Note: Modifiers may be in any order on the claim

Provider Manual Reference: loc ed serv psych

Module 2: Billing Requirements

Billing Structure - Common Billing Mistakes: Modifiers

Required Modifier Usage

Certain procedure codes require specific provider modifiers to be present for billing purposes. When the required modifier(s) is missing, the claim will be denied.

Procedure Code	Modifier(s)	Units	Billed Amount	Paid Amount
92508	TM	1	\$18.00	\$0.00
92508 always requires a GN modifier to be reimbursed.				
92508	TM GN	1	\$18.00	\$9.00
Correct				

Denies with RAD Code 9680:
This is an invalid modifier combination.
Resubmit with the correct modifier(s).

Provider Manual Reference: loc ed serv bil cd

Module 2: Billing Requirements

Billing Structure - Common Billing Mistakes: Modifiers

Extraneous Modifiers

Extraneous modifiers are modifiers (LEA and non-LEA) that are added to a procedure code when not required. When any modifier(s) is added to a procedure code, the claim will be denied.

Procedure Code	Modifier(s)	Units	Billed Amount	Paid Amount
T1003	TM TE	5	\$37.55	\$0.00

Denies with RAD Code 9680:
 This is an invalid modifier combination.
 Resubmit with the correct modifier(s).

T1003 does not require a practitioner modifier for reimbursement.

T1003	TM	5	\$37.55	\$18.80
-------	----	---	---------	---------

Correct

Provider Manual Reference: loc ed serv bil cd

Module 2: Billing Requirements

Billing Structure - Common Billing Mistakes: Units

Appropriate Billed Units

Initial treatment services have a maximum daily service limitation of 3 units. When the billed units are greater than 3, the claim will be denied.

Procedure Code	Modifier(s)	Units	Billed Amount	Paid Amount
92507	TM GN	8	\$392.72	\$0.00
92507	TM GN	3	\$49.09	\$24.55
92507	22 TM GN	5	\$73.65	\$36.85

Denies with RAD Code 0435:
The quantity billed for this procedure exceeds usual practice.

This initial treatment service claim has exceeded the maximum daily utilization of 3 units.

Correct

Provider Manual Reference: local service billed

Module 2: Billing Requirements

Billing Structure - Common Billing Mistakes: Rates

Under-Billing Reimbursement Rates

If a claim is billed with an amount less than the maximum allowable rate (or rate * billed units), the claim will be reimbursed at the lower billed rate.

Procedure Code	Modifier(s)	Units	Billed Amount	Paid Amount
97110	TM GO	3	\$13.90	\$13.90

There is no RAD Code associated with this billing mistake.

This initial occupational therapy claim was billed at the additional treatment service rate.

97110	TM GO	3	\$52.80	\$26.40
-------	-------	---	---------	---------

Correct

By billing incorrectly, the provider loses \$12.50 in reimbursement.

Provider Manual Reference: loc ed serv bil cd

