



How to Bill for a **School-Based Clinic**

MDwise is a Hoosier Healthwise/HIP Plan



Table of Contents

Introduction.....	3
The Importance of School-Based Clinics.....	3
Covered Services.....	4
Sick Visits.....	4
Well-Child Visits.....	4
EPSDT.....	5
Immunizations.....	6
Family Planning.....	7
Prenatal Care.....	7
School or Sports Physical.....	7
Drug and Alcohol Screening.....	7
Tobacco Cessation.....	8
Non-Covered Services.....	9
Individual Education Plans.....	9
Prior Authorization.....	9
CMS Form Example.....	10
MDwise Contacts and Additional Resources.....	12

Introduction

This provider toolkit is intended to serve as a guide for providers who provide preventive and other medical services to students in their community. It is intended to be a tool to provide direction to MDwise providers for submitting claims for covered services regardless of the provider's contract status and prior authorization for the list of services in this guide.

The Importance of School-Based Clinics

School-based clinics help improve the lives of Indiana children because they bring essential services to students in schools, homeless shelters or in group homes.

Advantages of School-Based Clinics

- Students have direct access to health care providers while they are at school where they spend a good portion of their daily lives.
- Students do not have to miss school or leave during important times of day for doctors visits.
- Parents do not have to miss work to take their children to doctor.
- Transportation barriers are reduced or eliminated.
- Behavioral issues can be identified through observation by medical professional and recommendations for appropriate behavioral health services can be made.
- Providers will receive reimbursement for covered services rendered in a school setting.
- Integrated care that covers both behavioral and medical services.
- Students will gain trust with health care providers in a school setting which will establish a pattern in their adult life.

Effectiveness of School-Based Clinics

- Improve health outcomes.
- Improve attendance.
- Improve behavioral issues.
- Decrease emergency room visits.
- Provide access to preventive services.

Covered Services

MDwise has determined that the following services will be reimbursed when rendered in a school-based, homeless or group setting:

- Sick visits.
- Well-child visits.
- EPSDT.
- Immunizations.
- Family planning.
- Prenatal care, pregnancy urine test only.
- Behavioral health.
- Drug and alcohol screenings.
- All other services will follow MDwise PA guideline requirements.

Note: If a service is provided by a Federally Qualified Health Center (FQHC), Rural Health Clinic or other medical clinic, that provider must submit these claims with place of service (POS) 03 – School-Based Clinic, 04 – Homeless Shelter, and 14 – Group Home in order to bypass out of network provider authorization requirements.

Sick Visits

Sick visits are examinations of new or established patients with a health care provider in an office or clinic where acute care is provided based on a presented illness or problem.

Sick visits are reimbursed for all diagnosis codes with the exception of behavioral health diagnosis codes. Providers billing for covered ancillary services performed on the same day of service and on the same claim form with the same POS (either POS 03, 04 or 14) will be reimbursed. Ancillary services billed with a different POS on a separate claim form from the sick visit must follow out of network authorization rules.

Office Visit Codes
99201-99215
99241-99245

Well-Child Visits

A well-child visit is a visit to a primary medical provider, generally when the member is not sick, and includes evidence of the following: a health and developmental history (physical and mental), a physical exam, and health education/anticipatory guidance. Elements of a well care visit must be in compliance to requirements as defined by the Indiana Health Coverage Programs (IHCP) and Federal and State regulations.

Well-child visits are defined by a preventive medicine evaluation and management (E&M) code (99381-99387, 99391-99397, 99461) and a preventive exam diagnosis code (G0438, G0439, Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9). If a well child visit also meets the guidelines for an EPSDT visit then it is billed with primary diagnosis code, V20.2. HCPCS codes G0438, G0439.

Note: There is a limitation of one well-child visit per member per year per place of service 03, 04, 14

For continuity of care reasons, MDwise highly recommends providers work with the member's primary medical provider (PMP). If the member wants to continue being seen by another primary care provider, the provider shall assist member's parent or custodian in making a PMP change to the rendering provider. MDwise customer service is available to assist in member transitions and they can be reached at 1-800-356-1204.

Evaluation & Management Codes	Diagnosis Code	HCPCS Codes
99381-99387, 99391-99397, 99461	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9 If a well-child visit also meets the guidelines for an EPSDT visit then it is billed with primary diagnosis code, V20.2.	G0438, G0439

EPSDT

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program referred to as HealthWatch and/or EPSDT in Indiana, is a preventive health care program designed to improve the overall health of eligible infants, children and adolescents. Special emphasis is given to early detection and treatment of health issues because these efforts can reduce the risk of more costly treatment or hospitalization that can result when detection is delayed.

Healthwatch/EPSDT services are available to Indiana Health Coverage Programs (IHCP) members from birth up to 21 years old (subject to limitations of each benefit package). Individuals enrolled in Hoosier Healthwise Package C are eligible for these services; however, treatment may be subject to benefit limitations.

EPSDT is a federally mandated set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Healthwatch/EPSDT screens are reimbursed at a higher rate than other well-child exams and physicals. All elements as outlined in the IHCP EPSDT Manual and state and federal regulations must be provided in order to obtain reimbursement for an EPSDT visit. For more information, see the EPSDT Manual at http://provider.indianamedicaid.com/ihcp/manuals/epsdt_healthwatch.pdf.

In order to claim a higher reimbursement, the following components of the screening must be provided and documented in the member's medical record: a comprehensive health and developmental history including assessment of both physical and mental health development, a comprehensive unclothed physical exam, nutritional assessment, developmental assessment, appropriate vision and hearing testing, dental observation, laboratory tests, including blood lead level (appropriate for age and risk factors), immunizations administered or referred (if needed at time of the screen), health education including anticipatory guidance, and administration of or referral for any other test, procedure or immunization that is medically necessary or clinically indicated.

- EPSDT visits are billed with primary diagnosis code of V20.2 and CPT codes 99381-99385, 99391-99395 and receive an enhanced reimbursement.
- If a member is evaluated and treated for a problem during the same visit as an EPSDT annual exam or well child service, the problem-oriented exam can be billed separately accompanied by the -25 modifier to identify a separate significantly identifiable E/M service. This includes E&M codes 99203 through 99215. The problem must require additional moderate level evaluation to qualify as a separate service on the same date.

- **Screening for blood lead toxicity for all children enrolled in Medicaid is a federal requirement.** The Office of Medicaid Policy and Planning (OMPP) requires that all children enrolled under Medicaid receive a blood lead screening test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning. Children younger than age 5 not seen in a school setting should be referred to the primary care provider for lead testing and management.
- Lead screenings are covered for the following codes: 83655 U1, 83655U2, and 83655.
- When a subsequent blood lead screening is performed, use the exposure diagnosis code (V15.86) in addition to the primary diagnosis code of V20.2.

If EPSDT exams result in referrals, follow up specialist visits should be coordinated by the members PMP and with in-network specialist for the member unless the providers are self-referral providers. For continuity of care reasons, MDwise highly recommends physicians work with the members Primary Medical Provider (PMP). If the member wants to continue being seen please assist member/custodian in making a PMP change to the rendering physician.

- In the event that the member has not had the required EPSDT or well care visit, the provider is encouraged to provide the more comprehensive examination at the time of the visit.
- The procedure codes and diagnosis codes are billed as defined in the well child definition above.
- There is a limitation of one well-child visit per member per year.

Immunizations

Immunizations are covered in accordance with the IHCP provider manual guidelines and any applicable IHCP provider bulletins and banner pages. These resources can be found at www.indianamedicaid.com. Immunizations are self-referral services and can be obtained from any IHCP enrolled provider qualified to render the service, whether or not the provider belongs to the MDwise network.

MDwise members can obtain immunizations from any IHCP enrolled provider qualified to render the service, whether or not the provider belongs to the MDwise network. Please refer to Policy PR12. Immunizations are defined by the following:

Immunizations: 90632, 90633, 90636, 90645, 90647, 90648, 90649, 90650, 90654, 90655, 90656, 90657, 90658, 90660, 90670, 90680, 90681, 90696, 90698, 90700, 90701, 90707, 90710, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90732, 90743, 90744, 90733, 90734, 90746, and 90748.* For HIP also includes: Q2037, Q2038. 90634 (3 dose of Hep A), 90646 (HIB booster), 90669 (Pevnar-PCV7) but may not be part of VFC.

**Bolded codes in the immunization section are not on the VFC available vaccines list in Section 4 of the EPSDT manual and are covered for members older than 18 years of age.*

Vaccine for Children Program (VFC)

All Hoosier Healthwise members 18 years old or younger are eligible for the VFC Program. For vaccines available through the VFC Program and provided to members age 18 years old and younger, the IHCP limits reimbursement to the fee for vaccine administration only. However, to address the need for immunizations and deal with potential shortage of available influenza vaccines, the IHCP does not limit reimbursement for any influenza vaccines, regardless of their availability from the VFC Program. This includes CPT codes 90654, 90655, 90656, 90658, 90660 and 90662. Also, to address an initial shortage

of available meningococcal vaccines under VFC, the IHCP does **not** limit reimbursement for MCV4 or Menactra vaccine, (CPT codes 90733, 90734) regardless of availability from the VFC program. This allows providers to obtain reimbursement for using privately purchased meningococcal vaccine if they cannot obtain VFC vaccine. When administering privately purchased meningococcal vaccine, providers may bill for the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement includes payment for both.

To be reimbursed for VFC vaccine administration, the provider must use **V20.2** as the primary diagnosis and the correct procedure code for the specific vaccine administered. A separate code for the administration of the vaccine should not be reimbursed. **IHCP reimbursement for VFC vaccine administration is the lesser of the provider's submitted charge for VFC vaccine administration or \$8.**

For combined vaccines, the provider should be reimbursed only one vaccine administration fee. If the only service performed is vaccine administration, providers cannot bill for an office visit. Providers can bill an office visit in conjunction with vaccine administration only when a significant, separately identifiable service is performed at the same visit.

Provider Purchased Vaccine

For vaccines not available through the VFC, for VFC shortage vaccines, and for vaccines administered to IHCP members older than 18 years old, IHCP providers should bill the CPT vaccine code as one line item and a CPT administration code (using CPT code 96372, 96373, or 96374 or for HIP, also codes G0008 – G0010) as an additional line item for reimbursement consideration. However, if an E/M service code is billed with the same date of service as an office-administered immunization, providers should not bill the vaccine administration code separately. Reimbursement for the administration is included in the E/M code-allowed amount. Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one vaccine is administered on the same date of service and no E/M code is billed, providers may bill an administration fee for each injection.

See the HealthWatch EPSDT Provider Manual at http://provider.indianamedicaid.com/ihcp/manuals/epsdt_healthwatch.pdf for any updates to the available VFC vaccines and reimbursement.

Family Planning

Family planning are services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. MDwise members can obtain family planning/self-referral services from any IHCP enrolled provider qualified to render the service, whether or not the provider belongs to the MDwise network.

Prenatal Care

School-based clinics, homeless shelters, and group homes can perform urine testing to confirm pregnancy. The member should be referred back to the PMP for the comprehensive prenatal examination, notification of pregnancy and ongoing prenatal care.

School or Sports Physical

The IHSAA form that is completed for sports physicals for athletics does not qualify as a wellness exam.

Drug and Alcohol Screenings

Screening and brief intervention (SBI) services are covered for the IHCP programs, effective October 1, 2008. SBI identifies and intervenes with individuals who are at risk for substance abuse-related problems or injuries. SBI facilitates dialogue between doctors and patients about the harms of substance abuse, risks for the disease of addiction, and strategies to help patients achieve sobriety.

SBI services use established systems (generally in non-behavioral health environment), such as trauma centers, emergency rooms, community clinics and school clinics, to screen patients who are at risk for substance abuse and, if necessary, provide them with brief interventions or referrals to appropriate treatment.

Reimbursable SBI procedure codes include:

- 99408 – Alcohol and/or substance abuse structured screening and brief intervention services, 15–30 minutes.
- 99409 – Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes.

Providers can bill procedure code 99408 or 99409 only after an individual has been screened for alcohol or drug abuse by a healthcare professional and it appears that a brief intervention is needed. SBI services are limited to **one structured screening and brief intervention per member, every three years when billed by the same billing provider.**

Prior Authorization:

One 99408 or 99409 is allowed without prior authorization, per member, **per billing provider.**

Tobacco Cessation

MDwise offers the SMOKEfree program at MDwise.org/providers/smokefree. In addition, providers can refer members age 13 and above to the Indiana Quitline at 1-800-QUIT-NOW (1-800-784-8669). Members will have access to tobacco cessation products and can speak with a coach to help them through quitting.

MDwise covers the following treatments:

- Gum.
- Patch.
- Lozenge.
- Nasal Spray.
- Inhaler.
- Prescription medication.
- Individual and group counseling.

Non-Covered Services

Reimbursement is not available for out-of-network provider services outside of those included in the covered benefits section without POS 03, 04 and 14 without prior authorization.

Individualized Education Plans (IEP)

An Individualized Education Plan, commonly referred to as an IEP, is mandated by the Individuals with Disabilities Education Act (IDEA). An IEP is the legal document that defines a child’s special education program. An IEP includes the disability under which the child qualifies for Special Education Services (also known as his classification), the services the team has determined the school will provide, his yearly goals and objectives and any accommodations that must be made to assist his learning. MDwise does not reimburse for IEPs. Reimbursement is provided by the Indiana Department of Education (IDOE). For more information regarding IEPs please visit <http://www.doe.in.gov/>.

Prior Authorization

Prior authorization is not required for POS 03, 04 and 14 for covered services regardless of network restrictions and prior authorization for listed procedure codes and specified provider specialties for members in a homeless shelter, group home or a health clinic operated in a school as specifically addressed in this policy. Please refer to the covered benefits section for details. All other services provided in these settings would follow PA guidelines.

One 99408 or 99409 is allowed without prior authorization, per member, **per billing provider.**

CMS Form Example

Instruction page for provider billing

1	Insurance Carrier Selection: Enter X for other.
1A	Insured's I.D. Number: Enter the member RID number must be 12 numeric digits.
2	Patient's Name: Enter last name, first name, middle initial.
3	Patient's Birth Date: Enter the member's birth date in MM/DD/YY format.
5	Patient's Address: Street number, city, state, zip code.
10	Is Patients Condition Related To: Enter X in the appropriate box in each of the three categories. This information is needed for follow-up third party recovery actions. If applicable (Workman's comp, auto accident)
11C	Insurance Plan Name or Program Name: Enter the member's insurance plan name or program name.
16	Dates patient unable to work if you entered "Yes" in Box 10A
17	Name of Referring Physician or Other Source: Enter the name of the referring physician. Required, if applicable.
17A	Enter the IHCP provider number of the referring physician. Required, if applicable.
17B	Enter the NPI number of the referring physician. Required, if applicable.
18	Hospitalization Dates Related to Current Services: Enter the requested from and to dates in MM/DD/YY format. Required, if applicable.
21A-21L	Diagnosis or Nature of Illness or Injury: Enter the ICD-9 CM diagnosis codes in priority order. A total of 12 codes can be entered. At least one diagnosis code is required for all claims.
23	Prior Authorization: Required, if applicable.
24A	Date of Service: Provide the from and to dates in MM/DD/YY format. Up to six dates are allowed per form. The from and to dates must be the same. No date ranges are allowed.
24B	Place of Service: Use the POS code for the facility where services are rendered.
24C	Emergency Service: Enter a Y if this was an emergency.
24D	Procedures, Services, Supplies: CPT/HCPCS use the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line.
24E	Diagnosis Pointer: Enter one to four pointers corresponding to the applicable diagnosis codes in Field 21. A minimum of one and a maximum of four diagnosis code references can be entered.
24F	\$ Charges: Enter the total amount charged for the procedure performed, based on the number of units indicated in field. The charged amount is the sum of the total units multiplied by the single unit charge. Each line is computed independently of other lines. This is an eight digit numeric field.
24G	Days or Units: Provide the number of units being claimed for the procedure code. Six digits are allowed, and 9999.99 units is the maximum that can be submitted. The procedure code may be submitted in partial units, if applicable.
24I	I.D. Qualifier: Enter ID for Medicaid.
24J	Indiana IHCP Provider Number: Enter the nine-digit number with the alpha location if applicable. Required at this time. Include NPI number on second line.
25	Federal Tax I.D. Number: Claims will not be accepted if this field is not completed.
28	Total Charge: Enter the total of column 24F charges. This is an eight-digit field.
31	Signature of Physician or Supplier including Degrees or Credentials: An authorized person, designated by the organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not.
32	Name and Address of Facility where Services are Rendered: Enter the provider's name and address. This allows us to contact the Provider if necessary.
33	Billing Provider Information and Phone: Number Enter the provider service location name, address and the ZIP Code+4 as listed on the provider enrollment profile.
33A	Billing Provider NPI: Enter the billing provider NPI.



DRAFT - NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLX LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street)		8. RESERVED FOR NUCC USE	
CITY	STATE	CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ()	ZIP CODE	TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____		SIGNED _____	
DATE _____		DATE _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17a. _____		17b. NPI _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. _____ B. _____ C. _____ D. _____		23. PRIOR AUTHORIZATION NUMBER	
E. _____ F. _____ G. _____ H. _____		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER	
I. _____ J. _____ K. _____ L. _____		F. \$ CHARGES G. DAYS OR UNITS H. EPICOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ()		a. NPI b.	
SIGNED _____		SIGNED _____	
DATE _____		DATE _____	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

MDwise Contacts and Additional Resources

MDwise Provider Home Page: MDwise.org/providers

MDwise Quick Contact Guide: MDwise.org/quickcontact

Additional Resources:

Indiana Medicaid: <http://provider.indianamedicaid.com/>

School-Age Children: <http://childparenting.about.com/od/schoollearning/a/IEP-Def.htmV>

HealthWatch EPSDT Provider Manual: http://provider.indianamedicaid.com/ihcp/manuals/epsdt_healthwatch.pdf