MSIC FFS and CMDP Billing 10/1/2018 Key Points

For dates of service on and after October 1, 2018, MSIC billing should follow the guidelines below (regardless of the currently registered Provider Type for the MSIC). MSICs will be flagged in the AHCCCS system to ensure that they are recognized and that appropriate rates are paid.

- Utilize the NPI for the MSIC as the rendering provider for the claim.
  (Note: Reimbursement for the T1015 – MSIC Service Coordination Payment, when appropriate, as well as use of the MSIC fee schedule, will only apply to the MSIC when the MSIC is the rendering provider, which is triggered by the MSIC NPI.)
- The MSIC may include all services provided to a member on a single date of service on one or multiple claim forms. If multiple claim forms, the MSIC NPI must be used as the rendering provider on each claim.
- MSIC-eligible visits may be billed with a T1015 procedure code once per day, per MSIC, and only when the member is a current CRS or former CRS member.
- Multiple visits in the same day by a single MSIC are eligible for only one T1015 code payment.
- The T1015 procedure code may be added to any of the claims which account for the member's visit on a single date of service, or may stand alone on a separate claim form.
- It is preferred that the MSIC bill utilizing the member's assigned AHCCCS ID. However, AHCCCS will accept a claim if the historically-assigned CRS ID is utilized.
- Bill on a Form 1500, in the 837 Professional format, on an ADA Form, or in the 837 Dental format, as appropriate to the type of MSIC visit. Only these Form types will permit reimbursement using the MSIC fee schedule, including reimbursement of the T1015 procedure code. For dental visits billed on either the ADA Form or the 837 Dental format, the MSIC may separately submit the T1015 procedure code on a Form 1500.
- If the MSIC bills a rate for a CRS or former CRS member that is less than the AHCCCS MSIC fee schedule, the AHCCCS "lesser of" reimbursement policy will prevail and cause the claim to be paid at billed charges rather than the MSIC fee schedule rate.
- If no covered procedure codes are reported for the T1015 date of service, no T1015 reimbursement will apply, except in the case of members with primary insurance or Medicare coverage. In these limited situations, the MSIC may bill the T1015 code to AHCCCS payers simultaneously with the billing of related services to the primary insurance. In this exception situation only, AHCCCS payers will either:
  - Hold the T1015 claim for a set period waiting for the EOB from the primary payer; or
  - Pay the T1015 claim, which then will be audited by the payer within a reasonable time period to ensure that the related services have been submitted and paid. If services have not been submitted and paid the T1015 claim may be subject to recoupment.

- Services which are typically “incident to” a visit, such as lab, radiology, immunizations or other testing, and pharmacy, but are not provided on the same date of service as a visit, are not eligible for T1015 reimbursement.
- In order to retain information related to the actual professional practitioner participating in or performing services associated with MSIC visits, the professional practitioner must also be reported on all claims as outlined below.

Reporting the professional (provider) participating in/performing services:

CMS Form 1500 (Paper Claim): ITEM NUMBER 19 - TITLE: Additional Claim Information (Designated by NUCC)

One Participating or Performing Provider – XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)ProviderName (last, first 20 characters)

Up to Two Participating or Performing Providers may be reported on a single claim – XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)Provider Name (last, first 20 characters) 3 blanks XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)ProviderName (last, first 20 characters)

ADA Form (Paper Claim): Field 35. Remarks

One Participating or Performing Provider – XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)ProviderName (last, first 20 characters)

Up to Two Participating or Performing Providers may be reported on a single claim – XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)Provider Name (last, first 20 characters) 3 blanks XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)ProviderName (last, first 20 characters)

837 Professional (Electronic Claim) and 837 Dental (Electronic Claim): 2300 NTE Loop

Loop	Element	Description 837-P 5010 A1 ENC	ID	Min. Max.	Use	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2300	**NTE**	**CLAIM NOTE**		**1**	**S**		
2300	NTE01	Note Reference Code	ID	3-3	R	Utilize assigned values	Expect ‘ADD’ – Additional Information

2300	NTE02	Claim Note Text	AN	1-80	R	Expect Claim Note Text	One Participating or Performing Provider - XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)ProviderName Up to Two Participating or Performing Providers may be reported on a single claim - XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)ProviderName XXProviderNPI(if a registerable Provider) or 9999999999(if not a registerable provider)ProviderName

- Do not enter a space, hyphen, slash or other separator between the qualifier code and the number or the NPI number and the Provider Name.
- XX is the actual Qualifier Code designated by the standards body to indicate an NPI.
- When reporting a second practitioner, enter three blank spaces and then the next qualifier and number/code/Provider Name.
- At this time the reporting of Participating Providers beyond 2 occurrences is not supported, as defined in the standards for the transaction.

Generally all Billing Rules, unless noted as exceptions, apply to both Medicaid-only as well as Medicaid secondary claims. Billing Instructions, with a Primary Payer other than AHCCCS to ensure appropriate processing, are outlined below.

When Medicare is primary payer:
Crossover claims may be received electronically from the Medicare plan with Medicare's specified coding that will not match to AHCCCS coding requirements for the inclusion of a T1015 code. In

this case the MSIC should submit a separate claim form with the T1015 code related to the visit or visits. On the claim form Medicare deductible/coinsurance/copay total amounts should be left blank (do *not* enter 0's).

If the Medicare claim did not electronically crossover from the Medicare plan, the MSIC may submit the T1015 code on the related visit claim or may submit a separate claim for with the T1015 code related to the visit or visits. On the claim form Medicare deductible/coinsurance/copay total amounts should be left blank (do *not* enter 0's).

When other coverage paid as primary:
The MSIC should submit the T1015 code on the related visit claim or may submit a separate claim form with the T1015 code related to the visit or visits.