Guide to Billing for Local Health Departments

2025

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Introduction

MDHHS awarded the Midland County Health Department a grant to develop a Local Health Department (LHD) Finance Guidebook, which will include a billing portion.
It has been realized that each LHD varies in programs and services and could contribute valuable information to others that may otherwise be difficult to obtain. The goal of this billing section is not to replace formal training, but to provide information and guidance to local health departments either starting to bill for new services or for new billing employees to have additional knowledge on various topics.

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Section 1

Billing Administration

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Credentialing and Enrollment

All providers, including the local health department (LHD), will need some sort of credentialing or enrollment completed before services can be offered to clients. The LHD is often listed as the billing provider, the facility and sometimes the rendering provider depending on the claim and the payer (insurance company being billed).

Several things to consider:

NPI's

General Information

- MDHHS requires all LHDs to have a Type 2 National Provider Identification (NPI) number.
- Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider Type 1 NPI number.
- A NPI number can be applied for at: NPPES (hhs.gov)
    - To get access to the NPPES website, you need to register a user ID on the CMS Identity & Access Management System first.

Type 1 NPIs

- A Type 1 NPI is for an individual provider. The number is associated with the person and not their specialty or a particular location. An individual can only have a single Type 1 NPI and it moves with them from employer to employer.
- Information for a Type 1 NPI can ONLY be changed by someone named on the NPPES page. It is highly recommended that the provider apply for their NPI themselves so they can access their profile. Applying themselves can also help the individual avoid a situation where a prior employer is listed as the administrator of their NPI, thereby, causing difficulties when making changes and the credentialing process being stalled.

Type 2 NPIs

- A Type 2 NPI is for an organization. It is sometimes referred to as the "billing NPI."
- Organizations can have multiple NPIs.

Tax ID

- Tax ID, or Tax Identification Number (TIN), is a number used by the IRS for identification purposes.
- This number is required when setting up contracts.
- It may vary by municipality type how Tax IDs are created, so reach out to your administrator to confirm the number.
- Tax ID is also an important number when it comes to receiving electronic remittances.
    - For this reason, it is very important to know if your tax ID is shared with another department that bills insurance, especially Medicaid.
    - Many payers allow you to choose to have remittances split by NPI or Tax ID. Fee for service Medicaid DOES NOT
    - For example, in Washtenaw County the Health Department and Community Mental Health share the same Tax ID as there is only one for the whole county. If the two departments use different EMRs, only ONE department can connect their EMR for electronic remittances.
        - Any change regarding this affects EVERY provider using that Tax ID.

Provider Licensing

- It is the responsibility of the individual provider to keep their license active.
- Keep updated copies of your providers' licenses as they are sometimes required to be submitted with payer network agreements.
- This includes your medical director's DEA license and Drug Control licenses which is required to prescribe certain medications.

CAQH

- CAQH is the acronym for The Council for Affordable Quality Healthcare, Inc.
- Many insurance companies now utilize CAQH information when credentialing providers.
- CAQH is a site that manages and stores professional and practice data, such as license information and board certifications.

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- This means the provider only needs to enter and update their information in one spot. This also streamlines the credentialing process; because insurance companies will ask for the provider's CAQH number and trust the information that is there, rather than each insurance company needing to verify license and certification information.

- Individual providers usually create their own CAQH login as the CAQH number moves with the individual and not a location. A provider may ask you for help gathering information and documents to add to their profile.

- You can register your Health Department for a CAQH as well.

- More information can be found here: CAQH - Making Healthcare Work Better.

CHAMPS

- You will need to add your health department as a "billing agent" in the CHAMPS profile of your medical director and any other type of mid-level or higher provider that will bill claims to Medicaid.
- This must be done by the domain administrator of the provider's CHAMPS profile.

CLIA

- A CLIA certificate of waiver allows certain lab tests to be performed and billed in-house.
- Claims for waived labs processed in-house must include modifier QW (see Appendix C for a list of tests that can be waived).
- Certificate should be displayed in the lab or where services are rendered.
- More information can be found here: Clinical Laboratory Services (michigan.gov).

Medicaid

Almost all local health departments (LHDs) participate as providers in the Medicaid Program as Public Clinics. The Medical Provider Manual chapter for Local Health Departments states that due to the Social Security Act, LHDs are a Title V Grantee.

Statutory basis for their participation is pursuant to 42 CFR 431.615 (Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees), thereby implementing Section 1902(a)(11) and (22)(C) of the Social Security Act.

A Title V grantee means an agency, institution, or organization that receives federal payments for part or all of the cost of any service program or project authorized by Title V of the Social Security Act, including:

- Children and youth projects
- Children's Special Health Care Services (CSHCS)
- Maternal and child health services
- Maternal and infant care projects
- Projects for the dental health of children.

Medicaid is usually the biggest payor for LHDs. Each provider must be enrolled as a Medicaid provider through a system called CHAMPS (Community Health Automated Medicaid Processing System).

This is the enrollment site, Provider Enrollment (michigan.gov). If you have any questions, you can email provider enrollment at, ProviderEnrollment@michigan.gov, or call the helpline at 800-292-2550 option4. The staff working in provider enrollment are quick to answer any questions you may have.

Clients with MA FFS (Medicaid Fee-For-Service) sometimes called Straight Medicaid, bill Payer ID 00111. These clients are not enrolled in a health plan and the state MDHHS office is the contact for them.

Most clients that have Medicaid are enrolled in a Medicaid Health Plan (MHP). This means they are enrolled in a commercial health insurance company's Medicaid Plan. For example. Blue Cross Blue Shield of Michigan has a Medicaid plan called Blue Cross Complete.

The Michigan Medicaid Manual provides useful information specific to Local Health Departments and spells out the rules and policies regarding billing, programs and services. This manual applies to MA FFS and MHP's. Each Health Plan may have additional rules and regulations that need to be followed in addition to the ones listed in the Manual.

https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

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Medicare

You will need to create an account at www.wpsgha.com, which is the Medicare portal for providers and billing staff. This allows you to verify eligibility and, depending on your access, look up claims and payments. It is good practice to log in each week so that your account stays active.

Provider and facility enrollment is done at: https://pecos.cms.hhs.gov/pecos/login.do#headingLv1 to be enrolled as a Medicare provider. There is a fee associated with becoming a roster biller. The fee for 2024 is 709.00. You can pay the fee on this site, Medicare Enrollment Application Information (hhs.gov).

Most health departments are just roster billers for Medicare. This means that they can only bill under Medicare part B for immunizations (Flu, Pneumonia, Covid-19, and Hep B if Moderate or High Risk) https://www.cms.gov/roster-billing.

Enrolling as a provider to bill Medicare Advantage plans is done through the individual payer sites. For example: BCBS's provider enrollment for commercial plans will/can also include their Medicare Advantage plans.

Clients either have Original Medicare or a Medicare Advantage (MA) plan. If the patient only has coverage through Original Medicare (the White, Blue and Red card), submit the claim directly to Medicare. For clients dually enrolled in both Medicare and Medicaid getting Part B vaccines, Medicare is billed first.

When billing for vaccines covered under Part D, most use TransactRx which requires enrollment as a Medicare provider as well as enrollment with TransactRx. (More information provided in Commonly Used Databases)

Most cannot bill Supplemental Medicare Plans and require the client to pay out of pocket and submit for reimbursement. Supplement Medicare plans cover copays and deductible for part A and part B services. Immunizations under part B do not have copays or deductibles. Therefore, Supplement plans do not cover part B immunizations or other immunizations that may be administered. Clients with Supplemental Medicare plans can only receive Part B immunizations billed through Original Medicare.

Medicare requires yearly compliance training for staff involved with Medicare patients. Here is the link to several trainings that includes required **Medicare Fraud & Abuse: Prevent, Detect, Report**: Web-Based Training | CMS.

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Commercial Payers

Many LHD's choose to become enrolled with other insurance companies. When filling out provider enrollment applications one thing to keep in mind is the Medicaid Health Plans your county/region has been assigned. These health plans are often tied to a commercial insurance company. The Provider Contract often includes all plan types that the company may offer, for example Medicaid, Medicare Advantage plans and Commercial plans. Some Payers require you to specify which plan types you are enrolling with.

For example: Livingston County Health Department completed provider enrollment for Priority Health and became contracted to bill their Medicaid, HMO/PPO, and Medicare Advantage plans.

- Each Payer has a unique ID that is used during claim submission to send the claim to the correct location.

Payer BCBS/Blue Care Network shares a Payer ID of 00710 and uses CFI's (Claim Filing Indicator's) to differentiate which plan it is.

EDI/EFT

EDI stands for Electronic Data Interchange. The claim information is sent electronically to the EMR in order to post the payment accurately.

EFT stands for Electronic Funds Transfer. This refers to sending or receiving money electronically.

Each payer requires forms that need to be completed to allow your EMR and Clearinghouse to send and receive the claims electronically as well as to set up payments with EFTs.

For the health departments that use Patagonia, the clearinghouse Office Ally has a place to search each payer and provides the necessary forms that are needed to complete.
Healthcare Software for Your Medical Practice | Office Ally

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Payer Websites

Each payer has their own website for providers that provides more information and details about eligibility, fee schedules, submitting claims and contact information. Some use third party sites for providers to access payment and claims data.

Often, the payer sites require a separate registration for each employee at a provider's location. Some base the registration off the Tax ID, which makes it difficult for multiple locations or departments that share a Tax ID.

For example, the Livingston County Health Department and the Livingston County EMS department share a Tax ID, so only one user can be the administrator for the payer site. Neither department shares anything else in common so it can be a hassle when updating payment methods or other information because it affects both departments.

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Commonly Used Databases/ Third Party Payer Sites

CHAMPS

One of the biggest payors for a health department is Medicaid. The system to enroll a provider in Medicaid is called CHAMPS (Community Health Automated Medicaid Processing System). If you follow the steps on CHAMPS, it should help you get through enrollment, Provider Enrollment (michigan.gov). If you have any questions, you can email provider enrollment at ProviderEnrollment@michigan.gov, or call the helpline at 800-292-2550 option4. The staff working in provider enrollment are quick to answer any questions you may have.

MI Health Benefits

This site allows you to check Medicaid Eligibility for multiple clients at a time (up to 15 clients in one submission). This works very well for the Hearing and Vision Program to check class lists quickly. Here is the link: https://hpb.mihealth.org/.

MCIR

The Michigan Care Improvement Registry (MCIR) is a database that documents immunizations given to individuals in Michigan. All children 20 years of age and younger must have their vaccines transmitted HL7 or entered into MCIR within 72 hours of administering the vaccine. You can access MCIR at mcir.org – Improving Healthcare in Michigan.

MCIR is also the resource center for all childcare centers and schools that have to report their immunization status to the local health departments. There are flyers, checklists and videos to help with questions the childcare centers and schools may have. All childcare centers must be compliant by reaching 90% on their roster by October 1st. All schools must be compliant by reaching 90% by November 1st and 95% compliant by February 1st.

MCIR will also show vision screenings, lead screenings, waiver status, and kindergarten oral health assessments.

Availity

Availity is a portal for providers and staff that helps provider transactions. You can search for eligibility and benefits, claim status, claim submissions, prior authorizations and much more. There is a payor space section where you can search for remits, provider enrollment or just education material. Many payors have begun using Availity like BCBS, BCN and Molina Healthcare. You can access Availity at Availity Essentials.

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Optum

Optum is a multi-payer adjudicated claims settlement service that delivers electronic payments and electronics remittances. Remittances from United Health Care and McLaren can be found here. You can access Optum at https://myservices.optumhealthpaymentservices.com/registrationSignIn.do

ECHO

ECHO is another multi-payer site where you can access electronic payments and electronic remittances. Remittances from Molina and Blue Cross Complete can be found here. Their site can be accessed at ECHO Provider Payments - Login.

TransactRx

Transactrx is a web-based platform where you can check patient's eligibility for Medicare Part D coverage. Health departments can bill most immunizations through Transactrx. Enrolling a new provider is a simple process and is done on their website, transactrx.com. There is no charge for using this system to bill out immunizations through Medicare Part D. Most immunizations have a zero-charge copay, but occasionally a copay is required. For example, clients receiving a vaccine out of the recommended age range due to a medical condition, may be required to pay a copay. Staff will need to collect it at the time of service.

Clients must sign Transact Rx Patient Signature Log Sheet for each vaccine administered as well as a Patient Acknowledgement form.

Payspan

Payspan has now become part of Zelis. Zelis is a multi-payer adjudicated claims settlement service that delivers electronic payments and electronic remittance advices based on your provider preferences. You can access Zelis at Modern Healthcare Financial Experiences are Built with Zelis.

WPS

WPS Government Health Administrator is a site where you can check on eligibility and claim status for Medicare patients. You can determine if the patient has straight Medicare or an HMO plan, which can be helpful when it comes to billing claims in your Immunization clinic. You can access WPS at WPS Government Health Administrators Home (wpsgha.com). One thing to note with this site, your password does expire every 60 days.

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NAVINET

NAVINET is a web-based portal that connects you to health plans. Once you enroll with the health plans, you can access eligibility, claims and benefits for members. This is helpful for checking claim status with Blue Cross Complete claims. You can access NAVINET at https://identity.navinet.net/.

Medicaid

The Medicaid Provider Website is https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/Medicaid-Providers. This provides information on the various programs local health departments may receive funding for and offer at their location.

The Medicaid Provider Manual has a lot of good information regarding billing for Local Health Departments. Here is the link to the Manual: MedicaidProviderManual.pdf (state.mi.us).

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Fee Schedules

You can access most payors fee schedules through their website. These fee schedules will list the maximum amount payable for a CPT or HCPCS code.

Your organization should have a procedure for calculating the fee to charge for your services and it should be consistent. There are a couple exceptions to this for health departments:

- We are only allowed to bill out a maximum fee of 23.03 for an administration charge when administering VFC vaccines
- When billing Medicaid and Medicaid Health Plans plans for contraceptive supplies, you can only bill out the actual 340B purchase price of the supply given.
- When billing out any medications in the Family Planning program, Communicable Disease program or the Sexually Transmitted Infection program, you can only bill medications that you have purchased, and these medications will also be billed out at the 340B purchase price.

Sliding Fee Scale

Sliding fee schedules are used to determine how much a client will pay out of pocket for a self-pay service based on their income. Sliding fee scales tend to be based off the federal poverty guidelines that are released each year, typically the 3rd week of January. You can find the guidelines at the following site, Poverty Guidelines | ASPE (hhs.gov).

Your organization should have a policy/procedure for how the SFS is applied and how income information is collected. This is a mandated field if you are a Family Planning clinic, as it is reported on the FPAR. This also helps ensure consistency and equity.

If you work in Patagonia, they may provide a spreadsheet to upload each year when the poverty guidelines are updated.

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Electronic Medical Records

Here are a few of the most commonly used EMR's at local health departments.

Patagonia Health- https://lhd2.patagoniaemr.com

Patagonia Health electronic health record system supports most local public health programs with applications specific to program needs. Patagonia Health continuously updates and enhances the system based on user needs and workflow requests. The following are some examples of programs supported by Patagonia: MIHP, Immunizations, Children's Special Healthcare Services, Behavioral Health, Hearing & Vision, and TB case management.

Some of the other features include a customizable clinic calendar; inventory log for medications and immunizations; MyHealth, an integrated patient portal; a communicator app used for patient reminders; various letter templates; a widespread reporting system; and a separate billing module for claims processing, billing reports, and patient ledgers and statements.

Epic – https://www.ehrinpractice.com

Epic is a cloud-based electronic health records system for hospitals and large practices. The Epic charting system includes features such as medical templates, patient history, and referrals; so that healthcare providers can deliver the best patient care. The Epic EHR database system includes patient records (EMR's) as well as reporting and analytics functionality. It offers the standard range of core EHR features and practices can add modules depending on specialty. It has an extensive patient portal and strong focus on facilitating remote care.

Mitchel and McCormick –

Mitchell and McCormick has merged with Harris Coordinated Care Solutions. You can find more information about their software solutions at the following site, healthcare (harriscomputer.com).

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Training Options

The health departments have a billing group that all billers should join. You need to contact MALPH and they will direct you to the correct person, Michigan Association for Local Public Health (malph.org).

Below are a few options for billing certifications or groups to join.

AAPC	Medical Coding - Medical Billing - Medical Auditing - AAPC
AMBA	United States Healthcare Billing Process | American Medical Billing Association
MMBA	Michigan Medical Billers Association (mmbaonline.org)

There are numerous certifications that you can obtain from AAPC. A few are list below.

CPC-Certified Professional Coder
CPB-Certified Professional Biller
COC-Certified Outpatient Coder

AMBA offers a couple of different billing certification options. A few are listed below

CMRS-Certified Medical Reimbursement Specialist
CMCS-Certified Medical Coding Specialist

MMBA does not offer certifications but does offer great support and local networking. They have a great network within the State of Michigan, a job board, and a Q&A section that members can post questions to and get answers from other members.

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Fraud and Abuse

All healthcare providers and their staff who bill Medicare or Medicaid, including physicians, nurses, administrative staff and anyone involved in patient care or billing practices, are required to complete the annual fraud and abuse training (FWA). There is some guidance on FWA training issued by the US Department of Health and Human Services, Fraud, Waste, and Abuse Training Requirements | Guidance Portal and Fraud & Abuse Laws | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services.

Fraud – The act of knowing and willfully executing, or attempt to execute, a scheme or deceit to defraud a health care insurance or benefit program.

Abuse - Healthcare abuse is the misuse of medical resources or services that result in unnecessary costs or poor quality of care.

As a biller, when you submit a claim for services performed for a Medicare or Medicaid patient, you are filing a bill with the Federal Government and certifying that you have eared the payment requested and complied with the billing requirements. Some examples of fraudulent billing are:

- Billing for services that you did not actually render
- Billing for services that were not medically necessary
- Billing for services that were performed by an improperly supervised or unqualified employee.

An annual training plan should be set in place in order to ensure that everyone is receiving the necessary training yearly.

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HIPAA- Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) was signed into effect by Congress August 1996. Under this federal law, the "Privacy Rule" establishes a set of national standards for the protection of certain health information as well as standards for individuals' privacy rights to understand and control how their health information is used. More information on the most current HIPAA Privacy Rule can be found at https://www.hhs.gov/hipaa/for-professionals/privacy/index.html.

Below are several HIPAA topics to be familiar with:

- Public Health Uses and Disclosures (Public Health Uses and Disclosures | HHS.gov)
- HIPAA Security Rule (Security Rule Guidance Material | HHS.gov)
- Breach Notification Rule (Breach Notification Rule | HHS.gov)
- Modifications to HIPAA under the Health Information Technology for Economic and Clinical Health Act (HITECH), referred to as the "Omnibus Rule". The final Omnibus Rule was created as a more stringent measure to protect the vital health information of patients and to provide them with access to their own health records. (What did the HIPAA Omnibus Rule Mandate?)
- Enforcement Process (Enforcement Process | HHS.gov)

It is important that health departments have a HIPAA compliance plan in place. A Compliance Plan is a set of policies and procedures that cover entities and business associates put in place to ensure they comply with all HIPAA regulations. This includes data security and employee training to breach notification procedures and monitoring for potential violations. A compliance plan should include the following.

- Policies and procedures for using and disclosing PHI
- Policies and procedures addressing restricting access to protected health information by employees
- Safeguards for protecting PHI, including administrative, physical, and technical safeguards
- Employee training on HIPAA regulations and breach notification procedures
- Monitoring for potential violations
- A compliance officer and compliance committee

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- Effective lines of communication
- Internal monitoring and auditing
- Disciplinary guidelines for enforcing standards
- A plan for responding to detected offenses
- Policy and procedure for reporting unauthorized disclosures to grantors

You can find information on HIPAA law on the US Department of Health and Human Services website, HIPAA Home | HHS.gov. In the end, you must be able to show that reasonable effort was made if a breach occurs.

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Section 2

LHD Programs

Descriptions and Overview

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Immunizations

All insurances that are compliant with the Affordable Care Act must provide coverage for recommended vaccines.

Vaccines for Children (VFC) is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated due to inability to pay. Health Departments get VFC vaccines for free. Because of this, we do not charge a fee for a VFC vaccine. We are still able to bill for an administration fee.

Table: Quick View of Insurance Situations and VFC Eligibility:

Child's Insurance Status	VFC-Eligible?	VFC Eligibility Category
Enrolled in Medicaid	Yes	Medicaid
Has private health insurance with Medicaid as secondary insurance.	See note	Note: See section below outlining two options.
Has insurance covering all vaccines but has not met plan's deductible.	No	Insured. This applies even when the primary insurer would deny reimbursement for the cost of the vaccine and administration because the plan's deductible has not been met.
Has insurance covering all vaccines, but the plan has a fixed dollar limit or cap on amount that it will cover.	See note	Note: Insured until the fixed dollar limit is met Underinsured after dollar limit is reached.
Has an insurance plan that does not cover all ACIP-recommended vaccines.	See note	Note: Underinsured for the vaccines not covered by insurance plan.
Has health insurance, but plan does not cover any vaccines.	Yes	Underinsured. With implementation of ACA, this situation should be rare.
Has no health insurance coverage.	Yes	Uninsured
Has private health insurance that covers all vaccinations and is AI/AN.	Yes, see note	Note: AI/AN are VFC-eligible. *However,* provider should choose the eligibility category **most cost-effective** for the child and family.
Has Medicaid and is AI/AN.	Yes	Medicaid or AI/AN. Provider should use Medicaid for the administration fee because this provides the least expense for the family.
Enrolled in a Health Care Sharing Ministry.	Yes, see note	Uninsured. A health cost sharing ministry is not considered health insurance (not recognized by the state insurance department), so any age-eligible child is eligible for VFC vaccine.

Note: This table is accurate as of 11/20/2024.

VFC Admin Fees

Medicaid VFC-eligible

- If a patient is Medicaid VFC-eligible, we must accept Medicaid reimbursement rate. No "balance billing" is allowed.

Non-Medicaid VFC-eligible

- If the patient is non-Medicaid VFC-eligible, the provider cannot charge more than the maximum regional charge.
  - At the time of writing this, that charge is $23.03/vaccine.

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- Providers must have a process to waive the fee if the patient or their parent(s) are unable to pay the administration fee. Unpaid fees may not be sent to collections, nor can a provider refuse to vaccinate an eligible child whose parents have unpaid vaccine administration fees.
- If your organization chooses to bill a non-Medicaid VFC-eligible child after the date of service, you can only send **a single bill.** This bill must be sent within 90 days of the date of service.

Private Insurance

- If a child is covered under a policy that covers the cost of vaccinations, they are NOT eligible for VFC vaccines. They are only considered un/under insured if their policy has a cap on what they will pay for preventive services and the cap has been hit.

Other Information

- There are programs that can help offset the cost of vaccines for adults, such as the Adult Vaccine Program (AVP). Your immunizations coordinator should have more detailed information. This can also be found on the MDHHS website. Clients that receive AVP vaccines are also charged an administration fee of 23.03 per vaccine. If your organization chooses to bill an AVP patient after the date of service, you can only send **a single bill.** This bill must be sent within 90 days of the date of service.

Family Planning

Michigan's Title X Family Planning Program provides high quality reproductive health care to women, men and teens at low or no-cost. The following services are available.

- Information on birth control and sexual health
- Help choosing the birth control method that best fits your life
- Help planning a healthy pregnancy when you want a baby
- Pregnancy testing and counseling
- Testing and treatment for sexually transmitted infections
- Preventive health exams to screen for cancer or other health issues

Family planning services are voluntary, confidential and affordable. All services charged directly to the patient are based on the Federal Poverty Guidelines. You will never be denied services for the inability to pay at a Family Planning clinic. Health departments are also able to bill Medicaid, Medicaid HMO plans and private insurance plans.

When a client is seen for services, there is mandated information that needs to be collected to report the information on the Family Planning Annual Report (FPAR). You can access these guidelines at the following site: https://opa.hhs.gov/research-evaluation/title-x-services-research/family-planning-annual-report-fpar.

Reasonable efforts to collect charges without jeopardizing client confidentiality **must** be made.

- At the time of services, clients who are responsible for paying any fee for their services should be offered bills directly. Bills to clients should show total charges less any allowable discounts. Sub-recipients **must** have the capacity to provide a bill to clients who request a bill.
- Sub-recipients **must** have a method for the "aging" of outstanding accounts. Written policies on billing and collections **must** include a policy on aging accounts and writing off outstanding accounts.

Voluntary donations from clients are permissible; however, clients **must not** be pressured to make donations, and donations **must not** be a prerequisite to the provision of services or supplies.

If your Family Planning clinic is enrolled in the 340B program, you must bill out the 340B purchase price when billing and issuing supplies. As an example, if your cost for a pack of birth control pills were $4.50, then you would bill $4.50 on your claim along with the NDC code for that birth control pill. All drug supplies billed out must have the NDC#, unit of measure, unit count and unit price on them. Providers must indicate drugs purchased through the 340B program using the modifier U6 for institutional and professional claims. If your clinic is not enrolled with 340B, here is the link to do that:

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340B Patient Definition Compliance Resources | HRSA.

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STI-Sexually Transmitted Infection

Services are available for teens and adults who may be at risk for STI's and/or HIV. Anyone who is sexually active can be seen. Clients are asked about current health status, risk factors, and sexual history. A physical exam and/or laboratory tests (urine, blood or swab collection) may be required. Some results will be available on the same day, while others may take up to 7 days. Treatment is provided. STIs are treatable and many are curable.

ALL SERVICES are CONFIDENTIAL.

- STI testing (urine sample) & treatment
- Rapid (20-minutes) & conventional HIV testing
- HIV risk assessment counseling
- Immunization assessment & administration
- Pregnancy testing & referrals
- Sexual health education & counseling
- Free condoms (male & female)

TESTING OFFERED:

- Urine: Chlamydia, Gonorrhea
- Blood: Syphilis, HIV
- Swab: Trichomoniasis (Trich), Herpes, Chlamydia, Gonorrhea, Bacterial Vaginosis (BV)
- Rapid Tests: HIV, Hep C, BV, Trich

STI clinics are allotted a certain amount of free testing forms from the State. These are normally utilized on patients that are uninsured or are requesting a confidential visit and do not want their insurance billed.

Each clinic may vary in the testing and treatment plans that they offer onsite.

WHO PAYS:
Services are provided on a sliding fee scale based on income. Insurance is accepted. No one is denied services due to their inability to pay.

Billable services include E/M codes, in-house labs (for CLIA waived tests) and collection of blood when there is no E/M service to bill. Remember when billing for an office visit, your patient must be established with a qualified healthcare professional before you can bill out an office visit in the STI clinic. Many STI clinics are staffed with nurses and therefore an office visit (99211-nurse visit) is not billable unless the patient has been established.

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TREATMENT:

STI clinics also offer expedited partner therapy (EPT) treatment. This is treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider examining the partner. There are times when the patient does not want to contact their partner, the clinic will then contact their partner anonymously and offer treatment to them. This can be done by either having a partner pick up medications at the clinic, or medications can be prescribed out for them.

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Hearing and Vision

Hearing and vision screens are provided in the school as well as at the local health department. There is no fee to families for this service. These services are billable to Medicaid for a select group of clients.

Hearing and vision screenings can only be billed for those ages 3 through 6 who have Medicaid.

Hearing and Vision is what is called a **carve out** program. This means that all claims will be billed to Fee-for-service Medicaid (also called Straight Medicaid), even if they are enrolled in a qualified health plan. Some LHDs do direct data entry into CHAMPS and others bill them through their EMR like all other claims.

The Hearing and Vision chapter in the Medicaid manual will also have information that is relevant for billing. Click here to learn about the program.

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WIC-Women, Infant and Children

The Women, Infants, and Children (WIC) program is a federally funded special nutrition program through the United States Department of Agriculture and is administered by MDHHS. This program services low and moderate income pregnant, breastfeeding, and postpartum women, infants, and children up to age five who are found to be at nutritional risk. You can find out more information about WIC at the following site, About the WIC Program (michigan.gov).

There is no billing for this program. LHDs are reimbursed for programs cost per the contract with MDHHS.

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CSHCS-Children's Special Health Care Services

Children's Special Health Care Services (CSHCS) does not bill client insurance plans for services rendered. However, CSHCS staff do bill the state program for Care Coordination, Case Management and Plans of Care. To bill for these services, staff must be able to prove with documentation that the services provided went above what is expected as base funding for the CSHCS program.

Staff records time spent (units) on those services in the Children's Healthcare Automated Support Services (CHASS) system found in the CSHCS database. From there, a report is run and submitted through the Financial Status Report (FSR) system based on the "fixed unit rate" method. Each of these services is paid at a different rate per unit.

Each CSHCS client is allowed a certain number of units per enrollment period for each of those services. CSHCS representatives can bill for Care Coordination, while only CSHCS nurses can bill for Case Management and Plans of Care.

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MIHP-Maternal Infant Health Program

The Maternal Infant Health Program (MIHP) provides free support for families during pregnancy and infancy. The MIHP program is an evidence-based home visiting program committed to providing education and resources for supporting a healthy pregnancy and a healthy baby. This program is not an essential part of health department services, and therefore, may not be offered at every health department. The MIHP team will consist of a coordinator, registered nurses, registered dietician and a licensed social worker. The program has eligibility requirements, which are:

- Pregnant individuals who are enrolled in, or eligible for Medicaid
- Families of infants under 12 months of age who are enrolled in, or eligible for Medicaid. Discharge is required by 18 months of age with transition to a more age-appropriate program.

Pregnant individuals are entitled to one (1) initial assessment and up to nine (9) professional visits, which are mostly in person, but can also be in the office, in a community setting or by telehealth, with one of those visits occurring postpartum. Pregnant individuals are also eligible for two (2) postpartum lactation visits.

Billing codes for pregnant individuals are as follows:

H2000 Risk Identifier Home Visit
H1000 Risk Identifier Office Visit or Community Visit
99402 Professional Visit-reimbursement depends on your place of service, home, office or community
S9442 Birthing Class
S9443 Lactation Class
S9444 Parenting Class

Infants under 12 months of age are entitled to one (1) initial assessment and up to nine (9) professional visits. Infants may qualify for an additional nine (9) visits via physician orders and up to 18 additional visits if an infant is substance-exposed for a total of 36 visits.

Billing codes for infants under 12 months of age are as follows:

H2000 Risk Identifier Home
H2000 Risk Identifier Community Visit
T1023 Risk Identifier Office
99402 Professional Visit-reimbursement depends on your place of service, home, office or community
96167 Infant Drug/Alcohol Exposed
96168 Infant Drug/Alcohol Exposed

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As of October 1, 2024, the codes listed below have been added to the fee schedule for MIHP

H1001 Additional Home Visit
99600 Complex Home Visit with Additional Face-to-Face Time
T2022 Enhanced Care Coordination Time
H1004 Discharge Visit

Mileage, bus rides or other transportation services for enrollees can be arranged through the individuals Medicaid plan. There are a variety of services that can be covered. Reach out to your health plan for the list.

You can find information about policies, training, and billing for the MIHP program at the following link, Maternal Infant Health Program (MIHP) (michigan.gov). The guidance manual and Medicaid manual can also found on the MIHP link noted above.

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Lead

Lead is an invisible threat that is found throughout our environment. A blood lead test can tell you if you have had recent exposure to lead. A lead test can be performed through a capillary (finger poke) or a venous (blood draw) test.

- It is the physician's responsibility to test or order the lead test.

- All children between the ages of 12 and 24 months are required to be tested for lead, or by 72 months of age.
- All children must also be tested as follows:
    - Between 48 and 60 months of age if they live in one of the 82 cities and townships designated by MDHHS as high risk. Visit the Lead Testing Jurisdiction webpage to view the list.
    - At least once between their most recent test and age 72 months if they are at high risk because they live in a home:
        - Built before 1978
        - Where other children with elevated blood lead levels live.
    - Within three months of when a physician or parent determines that they are at high risk. Risk factors to be considered are described in MDHHS Management of Blood Lead Test Results: Guide for Healthcare Providers.

The rules also include the following provisions:

- By law, parents can choose not to have their child's blood tested for lead. It is recommended this be documented in the medical record.
- All tests that are elevated based on capillary blood must be repeated with a venous test to confirm the elevated level.

This was a new law that went into effect on January 1, 2024. You can look in MCIR to see if the child has been screened. The blood lead module is a component of a patient's MCIR. The State lead website has additional resources you can reference, For Healthcare Providers (michigan.gov).

Billing codes will differ depending on what type of screen you do and if you own your own lead screening machine. If you do not have a lead screening machine, you would be doing a venous test and it would be sent out to a lab for processing. You will only be able to bill for a lab draw then, 36415. If you have your own LeadCare II diagnostic machine or another type of screening machine, then you can bill for the lead screening, 83655 and 36416. There seem to be some issues when these two codes are billed together. Some departments will bill one or the other to avoid denial all together. Blood lead draws are considered a carve out and can be billed to the MHP or Medicaid FFS.

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Dental Screening and Varnish

The Michigan Department of Health and Human Services, through the Varnish! Michigan Program will supply free fluoride varnish. Medicaid is reimbursing medical providers for providing oral screenings and applying fluoride varnish to their 0-5 age child patients.

There is training required for physicians and other staff involved in the MDHHS fluoride varnish program. Providers are required to collect certain oral screening data on each child fluoride varnish is applied.

As an LHD, we can bill out the codes below using a medical doctor as the Rendering Provider and the Nurse as the serviced-by provider.

CPT code D0190 with Dx code Z13.9
CPT code 99188 with Dx code Z29.3

Neither CPT code qualifies as a Visit for Medicaid Full Cost Reimbursement, but 99188 is included in Group 1.

Some LHDs choose to offer this in their WIC program, which works really well since the age of the children is the same. Some LHDs offer this during their home visits, but it could work during Immunization clinics as well. NOTE: if included during an immunization visit, a modifier may be required to bill out vaccines as well as the varnish on the same day.

Varnish! Michigan Free Fluoride Varnish Program for Medical Providers

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KOHA (Kindergarten Oral Health)

Public Act 316 of 2023 was enacted in December 2023 which requires all children enrolled in their first year of school, either kindergarten or first grade, to receive an oral health assessment (dental screening). This requirement began in the 2024-2025 school year.

This program is administered through MDHHS and is carried out through the local health departments at no cost to families. All children entering their first year of school are required to have a KOHA form completed and turned into the school. A child will not be excluded from school if they do not have this form completed on the first day of school. The assessment (screening) must be completed within 6 months of starting school or during the kindergarten school year through May 31st.

Local Health Departments are reimbursed for costs through their Comprehensive Agreements.

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WISEWOMAN-Well-Integrated Screening and Evaluation for WOMen Across the Nation

WISEWOMAN (**W**ell-**I**ntegrated **S**creening and **E**valuation for **WOM**en **A**cross the **N**ation) helps participants understand their cardiovascular disease (CVD) risk factors and make healthy lifestyle choices. Screening for Blood Pressure, Hemoglobin A1C, and Full lipid panels are part of the intake process.

WISEWOMAN is a federal program funded by the Centers for Disease Control and Prevention (CDC) and administered in Michigan by the Michigan Department of Health and Human Services.

Those who are eligible for the WISEWOMAN program include individuals who are:

- uninsured or underinsured;
- at or below 250% of the federal poverty guidelines; and
- 35 to 64 years of age.

Eligible clients who will benefit from this program include those who are at increased risk of heart disease and need preventive health screenings as part of their wellness routine.

*WISEWOMAN visits are encouraged and typically performed in conjunction with the BC3NP program visits. If both visits are on the same day only the BC3NP E/M visits will be paid. You can obtain more information about this program by visiting the WISEWOMAN PROGRAM webpage. You can also find the WISEWOMAN rate schedule and billing grid on this site.

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BC3NP-Breast & Cervical Cancer Control Navigation Program

The Breast & Cervical Cancer Control Navigation Program provides low-income women access to breast and cervical cancer screening services and follow-up care if needed. Any participating health department will be able to access if a patient is eligible and will have the paperwork for the patient to complete.

The BC3NP program is a federally funded program, funded by the Centers for Disease Control and Prevention and administered by the MDHHS. The program services the following eligible patients.

- Women
- Uninsured
- Underinsured
- At or below 250% of the federal poverty guidelines
- Ages 40-64 years for breast cancer screening/diagnostic/treatment services
- Ages 21-64 years for cervical cancer screening/diagnostic/treatment services
- Current Michigan residents

You can obtain more information about this program by visiting the webpage, Breast & Cervical Cancer Control Navigation Program (BC3NP) (michigan.gov). You can also find the BC3NP rate schedule on this site.

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Appendix A - Acronyms

Commonly Used Acronyms in Public Health

ACA	Affordable Care Act
BOL	Michigan Bureau of Laboratories
CD	Communicable Disease
CDC	Centers for Disease Control and Prevention
CHA	Community Health Assessment
CHIP	Children's Health Insurance Plan also Community Health Improvement Plan
CHW	Community Health Worker
CMH	Community Mental Health
CMS	Centers for Medicare and Medicaid Services
CSHCS	Children's Special Healthcare Services (project within the Comprehensive Agreement)
EGrAMS	Electronic Grants Administration and Management System (State of Michigan)
EH	Environmental Health
EP	Emergency Preparedness
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFS	Fee For Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSR	Financial Status Report
FTE	Full-Time Equivalent
FY/YTD	Fiscal Year/Year To Date
HIPAA	Health Insurance Portability and Accountability Act
HMP	Healthy Michigan Plan
HSA	Health Savings Account
IMMS	Immunizations
KOHA	Kindergarten Oral Health Assessment
LARA	Michigan Department of Licensing and Regulatory Affairs
LHD	Local Health Department
MAGI	Modified Adjusted Gross Income
MALPH	Michigan Association of Local Public Health
MCIR	Michigan Care Improvement Registry (Immunization Registry)
MDEQ	Michigan Department of Environmental Quality
MDHHS	Michigan Department of Health and Human Services
MDSS	Michigan Disease Surveillance System
MHAN	Michigan Health Alert Network
MHP	Medicaid Health Plans
MIHP	Maternal Infant Health Program
MIOSHA	Michigan Occupational Safety and Health Administration
NACCHO	National Association of County and City Health Officials
OSHA	Federal Occupational Safety and Health Administration

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PCP	Primary Care Physician/Provider
PHEP	Public Health Emergency Preparedness
RHC	Rural Health Clinic
STD/STI	Sexually Transmitted Disease/Sexually Transmitted Infection
VFC	Vaccines for Children (federal CDC program)
WIC	Special Supplemental Nutrition Program for Women, Infants and Children (federal USDA funded program)

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Appendix B – EFT/RA Reference

Availity - Aetna, All Blue Cross, Humana

- https://apps.availity.com/availity/web/public.elegant.login
    - Claims & Payments
        - Remittance Viewer
        - Humana Remittance Viewer-Search by VOUCHER date, only need transmittals for those listed as ACH, the NON and CHK do not need transmittals. Click on EOR (.pdf) for the RA. Select check to download, Download History page will appear. Click on your check# (file type Pdf) and save the RA in folder
    - BCBS and Aetna are Auto-posted in Patagonia
    - Humana can auto-post if uploaded- Click Download Text (X12), select check to be uploaded and Begin Download. Download History page will appear. Click on your check# (file type Text) and then upload it into Patagonia

Cigna - Cigna website

- https://cignaforhcp.cigna.com/app/login
- Reports
- Auto-posted in Patagonia

ECHO - **Deluxe checks**= Cofinity Network/ClaimsChoice, Meritain, Etc. send an email when new payments are available.

- Deluxe Payment Exchange (DPX) (echecks.com)
    - Checks-will display Deposit service fee at the top in red
        - Report fee as 602-8465 on transmittal but post full amount of check
    - Documents will have the Remittance Advice
    - Manual posting (some may appear on Misc-ECHO website with 835 that can auto-post)

HAP - Health Alliance Plan, Alliance Health & Life, HAP CareSource

- https://www.hap.org/
    - Menu Bar-click Remittance Advice
        - Auto-posted in Patagonia
    - Menu Bar- Click HAP CareSource
        - Claims, Payment History
            - Auto-posted in Patagonia

Humana Military -

- https://infocenter.humana-military.com/provider/service/Account/Login
    - Provider Claims
        - Remittance

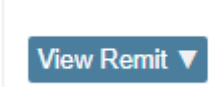
Medicaid

- Champs https://milogintp.michigan.gov/eai/tplogin/authenticate?URL=/
    - Auto-posted in Patagonia

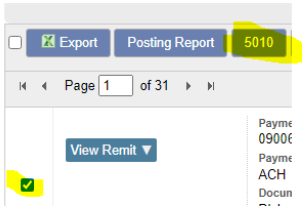
Medicare - wpsgha.com

- Remittance Advice

Meridian - Payspan (MHPMI)

- https://www.payspanhealth.com/NPS/Login?ReturnUrl=%2fNPS%2fVerifyUser
    - Your Payments
        - Click 

and Download PDF for your remittance
    - Auto-posts in Patagonia when ERA uploaded. Can load multiple checks at same time to limit number of batches
        - Check the box in the left column for all checks you want to upload and click on 5010 to download the info and then upload into Patagonia



And Change Healthcare Payments portal (52563)

- https://portal.paymentsconnector.changehealthcare.com/eops/all
    - All Remits

MISC- ECHO-Blue Cross Complete and Molina (Not CareSource)

- https://www.providerpayments.com/
    - BC Complete- auto post
    - Molina- will auto post if 835 is uploaded in Patagonia

Optum/OneHealthcare- McLaren, United Healthcare, UMR

- https://myservices.optumhealthpaymentservices.com/registrationSignIn.do
- View payments-  pdf for remittance advice, 

to download ERA
- Auto Post when ERA uploaded

Palmetto/GBA Railroad Medicare

- https://www.onlineproviderservices.com/ecx_improvev2/
    - Remittance
    - Auto-posted in Patagonia

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Priority Health

- Prism- https://provider.priorityhealth.com/s/login/?ec=302&startURL=%2Fs%2F
    - Resources- Filemart

Transact RX-

- https://app.mytransactrx.net/isinterfaces/
- Payments

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Appendix C – CLIA Waived Tests

A CLIA waived test is a lab test that has been determined to be simplified, and therefore, at a lower risk of error when performed in the office. Some examples of a CLIA waived test would be a glucose screening, pregnancy test, and some urine tests. If you are performing these tests at your health department, you will need a CLIA waived certificate. You can apply for this by doing to the website Waived Tests | CDC. You will complete the Form CMS-116. It is an easy form to complete. You will need your lab director's information to complete it. You can also visit this site for a complete list of the CLIA waived tests, CPT CODE(S) (cdc.gov). You can find more information on the State of Michigan's website, Clinical Laboratory Services (michigan.gov).

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