Definition of Medicaid Billable Visits

Background:
The "Phase 2 Funds Flow Distribution and Payment Schedule" refers to a "Medicaid impact measure" in Step 5. This measure of impact is 2015 billable Medicaid visits for PPS safety net partners. The below criteria should be used to define Medicaid billable visits.

Definition by Provider Type:

Hospital
- Inpatient admissions; number of cases
- Emergency Room visits, number of cases (exclude visits resulting in an inpatient admission case)

Primary Care, Non-Primary Care, and Urgent Care Clinics
- E&M codes:
  - 99201-99205 (new patient),
  - 99211-99215 (existing patient),
  - 99381-99397 (preventive visits), or
  - 99241-99245 (consult visits)

Long-Term Care, Skilled Nursing Facility, Nursing Home
- Days billable

Mental Health and Substance Abuse
- Service days

Home Health
- Per home visit

OPWDD
- Day Habilitation & Prevocational Waiver Services – has to occur weekdays before 3 PM – full unit – daily – 2 face to face contacts and 4-6 hours of service, ½ unit – 1 face to face contact and 2-less than 4 hours of service.
- Residential Habilitation – daily billing and one face to face service each day.
- SEMP- supported employment – 200 hours annually and billed in 15 minute increments for service
- Community Habilitation – daily billing and billed in 15 minute increments
- Respite – billed hourly
- Medicaid Service Coordination – billed monthly – type of case management

Exception:
As noted in the "Phase 2 Funds Flow Distribution and Payment Schedule", safety net providers who do not bill Medicaid will be categorized by their size as determined by number of employees serving the PPS region.

Committee/Board	Date	Revision 1
NCI DSRIP Finance Committee Approval	8/22/16	11/22/16
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