PROVIDER NOTICE

Federally Qualified Health Centers Claims Processing Guidelines

Policy ID:	HHO-RP-1002
Approved By:	Highmark Health Options – Market Leadership
Provider Notice Date:	5/14/2021
Original Effective Date:	6/15/2021
Annual Approval Date:	6/15/2022
Last Revision Date:	5/14/2021
Products:	Medicaid
Application:	N/A
Page Number(s):	89

Overview

This memorandum is intended to serve as a processing guide for submitting medical claims as they relate to Federally Qualified Health Centers (FQHC) as well as to highlight key discrepancies between the Delaware Health and Social Services (DHSS) Department of Medicaid and Medical Assistance (DMMA) and Highmark Health Options (HHO) documentation and policies as it relates to current claims payment methodologies and processing. The specific target audience for this information includes DMMA, internal HHO resources, and Delaware FQHC providers submitting medical claims under HHO FQHC provider policy.

BACKGROUND

Federally Qualified Health Centers (FQHCs) are outpatient centers that were developed in order to increase the overall quality of care within under-served communities. They are safety net health systems that provide primary care services through MCOs, as FQHC services are included in MCO benefits packages. In Delaware, all Medicaid members enrolled in HHO must receive all covered FQHC services through HHO. All FQHCs must be enrolled with a valid contract with the Delaware Medical Assistance Program (DMAP) and be licensed under the Delaware state agency responsible for licensing and certification.

Services provided by a Physician, Nurse Practitioner, Physician Assistant, Nurse Midwife, Clinical Psychologist, and Clinical Social Worker are payable only to the FQHC. The services furnished must be under the scope of the aforementioned providers. An encounter is defined as a face-to-face visit between a patient and any aforementioned health professional whose services are reimbursable under DMMA FQHC provider policy.

FQHC services must be provided in an outpatient setting. Visits to a hospital (including emergency room) or other inpatient services provided by FQHC practitioners are not considered a reimbursable FQHC encounter and are not payable to the FQHC. Inpatient services are payable only to individually enrolled physicians or physician group.

FQHC SERVICES

1. Covered Services
   FQHC providers and services include:
   - Physician Services
     - May include diagnosis, therapy, surgery and consultation
   - Nurse Practitioner Services
   - Physician Assistant Services
   - Nurse Midwife Services
   - Clinical Psychologist/Clinical Social Worker Services
   - Services & Supplies Incident to Services
   - Preventive Primary Care Services
     - Medical social services.
     - Nutritional assessment and referral.
     - Preventive health education.
     - Children's eye and ear examinations.
     - Prenatal and postpartum care.
     - Perinatal services.
     - Well child care: periodic screening, fluoride varnish and oral health risk assessment.
     - Immunizations.
     - Voluntary family planning services.
     - Taking patient history.
     - Blood pressure measurement.
     - Weight.
     - Physical examination targeted to risk.
     - Visual acuity screening.
     - Hearing screening.
     - Cholesterol screening.
     - Stool testing for occult blood.
     - Dipstick urinalysis.
     - Risk assessment and initial counseling regarding risks.
     - Tuberculosis testing for high-risk patients.
     - For women only: clinical breast exam, referral for mammography, and thyroid function test.

All services provided at the center by a physician, nurse practitioner, physician assistant, nurse midwife, clinical psychologist, and clinical social worker are payable only to the FQHC. Services are reimbursable, if performed at the center and are within the scope of the clinician's licensure and are furnished in accordance with any medical orders under the medical supervision of a physician, unless stated otherwise as an exception within the DMMA FQHC Provider Policy Manual.

2. Covered Services Reimbursed Separately
   These services are reimbursed separately and are billed alone or with other payable services on a FQHC claim. Providers are required to bill all appropriate services for each encounter, regardless of if the services are separately reimbursed. Providers are also required to document all screenings performed, including all Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

3. Long Acting Reversible Contraception Services (LARC) Codes
   The following billing instructions are required for successful submission of LARC Codes. See Appendix.

- LARC Claims can be submitted in two ways:
  - Claim with a J-Code, but no Encounter Code.
  - Claim with both an Encounter Code and a J-Code.
- Reimbursement will be based on HCPCS code for LARCS being one of the following and must include an associated National Drug Code number (NDC #)
- A charge amount must be included on the J-Code line.

4. Chronic Care Management
   HHO follows the CMS FQHC Prospective Payment System requirements for claim submissions under Chronic Care Management (CCM). Effective January 1, 2018, HCPC Code G0511 is reported for CCM. Payment is set annually at the average of the national non-facility PFS payment rate for CPT Codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services, and 99484 (20 minutes or more of general behavioral health integration services).

5. Non-Covered Services
   - Physician telephone services.
   - Physician prescription services (visits for the sole purpose of obtaining or renewing a prescription).
   - Drugs and biologics that can be self-administered.
   - Eyeglasses.
   - Hearing Aids.
   - Group or mass information programs, health education classes, or group education activities, including media productions, and publications.
   - Screening mammography (unless service meets the applicable requirements specified I 42 CFR §410.34).
   - Preventative dental services with the exception of fluoride varnish (administered for children age 18 and under through DMAP).

PROVIDER BILLING INFORMATION

FQHC services shall be billed per “medical encounter.” Claims are limited to one all-inclusive “encounter” per day, to include all services received by an eligible recipient on a single day or relevant to the “encounter.” The exception allows two encounters to be billed in one day, if one encounter is a medical visit and the second encounter is a mental health visit. See Appendix.

All subsequent services and follow-up care provided by other than a physician, nurse practitioner, or physician’s assistant, ordered as a result of an “encounter” are included in the related “encounter” rate, and are not billed separately.

Providers must bill HHO using an FQHC HCPCS (Healthcare Common Procedure Coding System) “G” visit payment code for each payable encounter visit, along with a HCPCS code for each service provided. Claims must be submitted with the correct Place of Service (POS).

G VISIT PAYMENT CODES (TAKEN FROM FEE SCHEDULE)

Proc Code	Description	Rate Type
G0466	FQHC visit new patient	PRB
G0467	FQHC visit, ESTAB PT	PRB
G0468	FQHC visit, IPPE or AWV	PRB
G0469	FQHC visit, MH new PT	PRB
G0470	FQHC visit, MH ESTAB PT	PRB

1. CPT Code T1015
   Providers should use CPT Code T1015 for all School Based Wellness (SBW) claims. Providers should not use CPT Code T1015 for FQHC Clinic Services and should use the FQHC HCPCS G-Code payment codes for each payable encounter.

PROVIDER BILLING DISCREPANCIES IN DOCUMENTATION

The following exceptions to the requirement that only one “encounter” may be billed per day are not detailed in HHO policies or process documentation:

- Exception is made for cases in which the patient, subsequent to the first “encounter” suffers illness or injury requiring additional diagnosis or treatment on the same day.
- Exception is also made if the patient has a medical visit and another health visit for mental health services on the same day.
- A practitioner may bill HHO for admitting and attending an eligible Medicaid recipient in an inpatient setting if the member is enrolled with HHO as an individual/group provider. These services cannot be billed using the provider number assigned to the FQHC.

BILLING FORMAT

FQHCs and Rural Health Clinics (RHCs) may submit claims for medical encounters provided to HHO members on paper CMS 1500 forms or electronic 837P claim forms. Medicare crossover claims must come in on UB Format UB-04 (equivalent to CMS-1450 & electronic submission code 837I). See Appendix.

TELEMEDICINE

Telemedicine or telehealth FQHC services are to be billed with their appropriate G-Code, along with the corresponding telemedicine/telehealth procedure code to fulfill all billing and encounter requirements. (Additional details can be found in the Highmark Health Options Delaware COVID-19 Expanded Telemedicine Policy, RP-01-COVID.)

REIMBURSEMENT METHODOLOGY

HHO will reimburse at the DMMA FQHC Rate Schedule, unless otherwise stated in the provider’s contract.

The DMAP reimbursement methodology details for FQHC reimbursement rates are as follows: The rate year for FQHC services is July 1 through June 30. FQHCs are required to submit a Medicaid Cost Report annually, due within 90 days after the provider's fiscal year end. This payment methodology will conform to the BIPA 2000 Requirements Prospective Payment System (PPS). FQHCs are assigned a prospectively determine rate per encounter based on actual reported costs.

CMS requires that all FQHCs be reimbursed in compliance with section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. Effective July 1, 2018, HHO will reimburse each FQHC per-visit through one of the following two methodologies, whichever nets the greater results:

- The PPS rate, where 100 percent of the reasonable costs based upon an average of their fiscal years 1999 and 2000 audited cost reports are inflated annually by the Medicare Economic Index (MEI); or
- The per-visit cost as reported by the FQHC in its most recent cost report, subject to an audit performed by a certified public accountant as to the reasonableness of the reported costs.

Primary Care costs and Administrative and General Costs are each reviewed individually for purposes of rate calculation. The Administrative and General component is capped at 40% of the total cost. Each cost component is inflated by the current CMS Medicare Economic Index (MEI).

Note: An encounter is a unit of service for which the FQHC PPS rate is computed. At the beginning of each new rate year, DMAP will consider a request to change the definition of encounter. However, any change in definition (not related to a change in scope or change in costs) that would increase the number of billable encounters will require DMAP to compute a lower PPS rate. Conversely, any change in definition that would decrease the number of billable encounters will require DMAP to compute a higher PPS rate. Rendering providers must be enrolled as a participating provider with the billing FQHC.

Reference

Policy Update History

5/14/2021	Provider Notification

Appendix

FQHC LARC BILLING AND CLAIMS GUIDELINES

1. LARC Claims can be submitted in two ways:
   - Claim with J-Code, but no Encounter code (G0466, or G0467), submitted separately. To be paid, this claim must find a paid Medical claim with Encounter Code T1015, G0466, or G0467 submitted for same date of service (DOS) already. If no corresponding claim is found, then J-Code claim is to be denied.
   - Claim with both Encounter code (T1015, G0466, or G0467) and J-Code (J7296, J7297, J7298, J7300, J7301, or J7307) with associated NDC number on the same claim will be paid.
   - Per HHO billing guidelines, regardless of the claim submission selected, an associated NDC number must be included with each J-Code submitted.
2. Reimbursement will be based on HCPCS code for LARCs being one of the following:
   - J7296 Levonorgestrel – Releasing Intrauterine Contraceptive System, (Kyleena), 19.5 mg
   - J7297 Levonorgestrel – Releasing Intrauterine Contraceptive System, (Liletta), 52 mg
   - J7298 Levonorgestrel – Releasing Intrauterine Contraceptive System, (Mirena), 52 mg
   - J7300 Intrauterine Copper Contraceptive
   - J7301 Levonorgestrel – Releasing Intrauterine Contraceptive System, (Skyla), 13.5 mg
   - J7307 Etonogestrel (Contraceptive) Implant System, including implant and supplies
3. A charge amount must be included on the J-Code line.

FQHC MEDICAL ENCOUNTER BILLING GUIDELINES

When billing two claims for the same DOS:

1. Medical Encounter must be billed on its own, without mental health claim.
2. One of the encounter codes below must be listed in addition to the related fee-for-service procedure codes in order for the claim to process:
   - G0466 – New Patient
   - G0467 – Established Patient
3. In addition, the encounter must be accompanied by one of the ‘Qualifying Visit’ services listed below:
   - G0466 – FQHC visit, new patient
     - 92002 Eye Exam new patient
     - 92004 Eye Exam new patient
     - 97802 Medical nutrition indiv in
     - 99201 Office/outpatient visit new
     - 99202 Office/outpatient visit new
     - 99203 Office/outpatient visit new
     - 99204 Office/outpatient visit new
     - 99205 Office/outpatient visit new
     - 99304 Nursing facility care init
     - 99305 Nursing facility care init
     - 99306 Nursing facility care init
     - 99324 Domicil/r-home visit new pat
     - 99325 Domicil/r-home visit new pat
     - 99326 Domicil/r-home visit new pat

  - 99327 Domicil/r-home visit new pat
  - 99328 Domicil/r-home visit new pat
  - 99341 Home visit new patient
  - 99342 Home visit new patient
  - 99343 Home visit new patient
  - 99344 Home visit new patient
  - 99345 Home visit new patient
  - 99406 Behav chng smoking 3-10 min
  - 99407 Behav chng smoking > 10 min
  - 99497 Advanced care plan 30 min
  - G0101 Ca screen; pelvic/breast exam
  - G0102 Prostate ca screening; dre
  - G0108 Diab manage trn per indiv
  - G0117 Glaucoma scrn hgh risk direc
  - G0118 Glaucoma scrn hgh risk direc
  - G0296 Visit to determ LDCT elig
  - G0442 Annual alcohol screen 15 min
  - G0443 Brief Alcohol misuse counsel
  - G0444 Depression screen annual
  - G0445 High inten beh couns std 30 min
  - G0446 Intens behave ther cardio dx
  - G0447 Behavior counsel obesity 15 min
  - G0490 Home visit RN, LPN by RHC/FQ
  - Q0091 Obtaining screen pap smear
- G0467 – FQHC visit, established patient
  - 92012 Eye Exam establish patient
  - 92014 Eye Exam & tx estab pt 1/>vst
  - 97802 Medical nutrition indiv in
  - 97803 Med nutrition indiv subseq
  - 99212 Office/outpatient visit est
  - 99213 Office/outpatient visit est
  - 99214 Office/outpatient visit est
  - 99215 Office/outpatient visit est
  - 99304 Nursing facility care init
  - 99305 Nursing facility care init
  - 99306 Nursing facility care init
  - 99307 Nursing fac care subseq
  - 99308 Nursing fac care subseq
  - 99309 Nursing fac care subseq
  - 99310 Nursing fac care subseq
  - 99315 Nursing fac discharge day
  - 99316 Nursing fac discharge day
  - 99318 Annual nursing fac assessment
  - 99334 Domicil/r-home visit new pat
  - 99335 Domicil/r-home visit new pat
  - 99336 Domicil/r-home visit new pat
  - 99337 Domicil/r-home visit new pat

- 99347 Home visit est patient
- 99348 Home visit est patient
- 99349 Home visit est patient
- 99350 Home visit est patient
- 99406 Behav chng smoking 3-10 min
- 99407 Behav chng smoking > 10 min
- 99495 Trans care mgmt 14 day disch
- 99496 Trans care mgmt 7 day disch
- 99497 Advanced care plan 30 min
- G0101 Ca screen; pelvic/breast exam
- G0102 Prostate ca screening; dre
- G0108 Diab manage trn per indiv
- G0117 Glaucoma scrn hgh risk direc
- G0118 Glaucoma scrn hgh risk direc
- G0270 Mnt subs tx for change dx
- G0296 Visit to determ LDCT elig
- G0442 Annual alcohol screen 15 min
- G0443 Brief Alcohol misuse counsel
- G0444 Depression screen annual
- G0445 High intens beh couns std 30 min
- G0446 Intens behave ther cardio dx
- G0447 Behavior counsel obesity 15 min
- G0490 Home visit RN, LPN by RHC/FQ
- Q0091 Obtaining screen pap smear

FQHC WELL VISIT/PREVENTIVE VISIT

The below encounter code must be listed in addition to the related procedure codes in order for the claim to process:

- G0468 -- Federally qualified health center (fqhc) visit, that includes an initial preventive physical examination (ippe) or annual wellness visit (awv)

In addition to the G0468 encounter code, one of the following qualifying codes must be listed in order for the claim to process:

- G0402 Initial Preventitive Exam
- G0438 Ppps, Initial Visit
- G0439 Ppps, Subseq Visit

FQHC MENTAL HEALTH

1. Mental Health Encounter must be billed on its own, without medical claim.
2. The below encounter code must be listed in addition to the related fee-for-service procedure codes in order for the claim to process:
   - G0469 – New patient
   - G0470 – Established patient

3. In addition, the encounter code G0469 or G0470 must be accompanied by one of the 'Qualifying Visit' services listed below:
    - 90791 Psych diagnostic evaluation
    - 90792 Psych diag eval w/ med srvcs
    - 90832 Psytx pt &/family 30 minutes
    - 90834 Psytx pt &/family 45 minutes
    - 90837 Psytx pt &/family 60 minutes
    - 90839 Psytx crisis initial 60 min
    - 90845 Psychoanalysis

New Patient Visits

If a new patient is receiving both a medical and a mental health visit on the same day, the patient is considered 'new' for only one of these visits and it must be the medical visit. The FQHC should use G0466 for the medical visit and G0470 for the mental health visit.