INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Federally Qualified Health Centers and Rural Health Clinics

LIBRARY REFERENCE NUMBER: PROMOD00028
PUBLISHED: FEBRUARY 13, 2017
POLICIES AND PROCEDURES AS OF APRIL 1, 2016
(*Core*MMIS UDPATES AS OF FEBRUARY 13, 2017)
VERSION: 1.2

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: December 15, 2016	Semiannual update: • Updated *FQHC and RHC Billing and Reimbursement* section: – Added cross-reference for managed care entity (MCE) information – Added reference to *CMS-1500* paper claim to billing information • Added reference to the *Prenatal and Preventive Pediatric Care Diagnosis Codes* table, clarified text, and removed reference to spend-down in the *Third-Party Liability Considerations* section • Added references to paper claim forms and clarified text in the *Medicare Processed Claims Submitted to the IHCP by the Provider* section • Updated policy and billing information in the *Managed Care* section • Added place-of-service code 19 to the *Hospital Services* section	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	• Changed Indiana*AIM* references to *Core*MMIS • Added Provider Healthcare Portal information to billing and enrollment instructions throughout the module • Changed Legacy Provider Indicator (LPI) references to Provider ID • In the *FQHC and RHC Billing and Reimbursement* section, added instructions for submitting multiple diagnosis codes on a single claim	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
		• In the *Third-Party Liability Considerations* section, removed reference to applying spend-down and waiver liability to the total amount due • Updated the *Medicare Processed Claims Submitted to the IHCP by the Provider* section to include submitting Medicare information at the detail level for applicable claim types; changed Medicare Remittance Notice (MRN) references to Explanation of Medicare Benefits (EOMB)	

Table of Contents

Federally Qualified Health Centers and Rural Health Clinics

Note:	*For policy information regarding coverage of services provided by a federally qualified health center or rural health clinic, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) were designated to provide healthcare services to underserved urban and rural communities. FQHCs receive government grants, which help them provide primary care services to all patients, regardless of their ability to pay. RHCs have increased the use of nonphysician practitioners, such as physician assistants and nurse practitioners, in rural areas. The Indiana Health Coverage Programs (IHCP) requirements for FQHCs and RHCs are described in the following sections.

Federally Qualified Health Centers

FQHCs receive funds through the Public Health Service (PHS) and are designated as such. FQHC look-alikes meet the same criteria as FQHCs, but do not receive PHS funding and have not been given FQHC status by the Centers for Medicare & Medicaid Services (CMS). For information regarding this process, contact the Indiana Primary Health Care Association at (317) 630-0845.

To enroll as an FQHC with the IHCP, providers should forward the CMS letter granting them FQHC status, along with their completed application, to the Provider Enrollment Unit. (See the *Provider Enrollment* module for details about the IHCP provider enrollment process.) The provider must also submit the proper financial documents to Myers and Stauffer, the IHCP rate-setting contractor, to have a reimbursement rate determined for the FQHC. Myers and Stauffer forwards the rate document to the Provider Enrollment Unit so the encounter rate can be loaded into the Core Medicaid Management Information System (*Core*MMIS). Each time the facility expands or decreases the scope of service and receives an adjustment to its encounter rate, Myers and Stauffer must forward a new rate letter to the Provider Enrollment Unit to ensure that reimbursement remains accurate.

Rural Health Clinics

RHC services are defined in *Code of Federal Regulations 42 CFR 405.2411* and *42 CFR 440.20*. RHCs receive Medicare designation through the CMS. Clinics must contact the Indiana State Department of Health (ISDH) to request RHC status for the IHCP. The IHCP requires all RHCs to submit finalized (reviewed or audited) cost reports and copies of their Medicare rate letters to Myers and Stauffer. For more information about becoming an RHC under the IHCP, contact the ISDH, the Indiana Primary Health Care Association, at (317) 630-0845, or other practice consultants.

Each time a facility expands or decreases its scope of service and receives an adjustment to its encounter rate, Myers and Stauffer must forward the new rate letter to the Provider Enrollment Unit to ensure that reimbursement remains accurate.

FQHC and RHC Billing and Reimbursement

> *Note:* *The following billing and reimbursement information applies to fee-for-service claims billed to Hewlett Packard Enterprise. For information about FQHC and RHC billing and reimbursement for members enrolled in a managed care program, see the Managed Care section of this document.*

In accordance with Section 702 of the *Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000* (BIPA), the IHCP implemented the prospective payment system (PPS) for reimbursing FQHCs and RHCs for IHCP-covered services. FQHCs and RHCs receive a facility-specific PPS rate determined by Myers and Stauffer. Myers and Stauffer forwards the specific PPS rate information to Hewlett Packard Enterprise, and the Provider Enrollment Unit loads the rate for reimbursement of Healthcare Common Procedure Coding System (HCPCS) code T1015 – *Clinic, visit/encounter, all-inclusive* to the specific provider enrollment file for reimbursement.

Providers must submit claims for valid FQHC and RHC encounters with a place of service of 11, 12, 31, 32, 50, or 72. All FQHC and RHC facilities are required to submit claims using HCPCS Level III codes, including encounter code T1015, and Level I and Level II HCPCS procedure codes. Providers **must use** the T1015 encounter code and Current Procedural Terminology (CPT®[1]) or HCPCS procedure codes. The claim logic compares the other CPT or HCPCS codes used to a list of valid CPT and HCPCS codes approved by the Family and Social Services Administration (FSSA). If the claim contains T1015 and one of the allowable procedure codes from the encounter criteria, the CPT or HCPCS codes are denied for explanation of benefits (EOB) 6096 – *The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology*.

The encounter rate (T1015) is reimbursed according to the usual and customary charge (UCC) established by Myers and Stauffer from the provider-specific rate on the provider file. The provider should not resubmit CPT or HCPCS codes separately that were denied for EOB 6096.

Providers should identify all services provided during the visit using all the appropriate CPT and HCPCS codes. If the CPT or HCPCS codes billed do not contain one of the procedure codes included in the list of allowable procedure codes from the encounter criteria for place of service 11, 12, 31, 32, 50, or 72, the claim is denied for EOB 4124 – *The CPT/HCPCS code billed is not a valid encounter*. Providers should not resubmit claims denied for EOB 4124 for payment. (See the Myers and Stauffer website at in.mslc.com for a complete list of CPT and HCPCS codes that meet the criteria for a valid FQHC or RHC encounter. The list is revised on an annual basis.)

Additionally, claims submitted with a place of service 11, 12, 31, 32, 50, or 72 that do not have the T1015 code present on the claims are denied for EOB 4121 – *T1015 must be billed with a valid CPT/HCPCS code.* Providers can resubmit these claims with the T1015 code properly included on the claim.

Providers can submit claims on the *CMS-1500* claim form or electronically using the 837P transaction or the Provider Healthcare Portal (Portal) professional claim submission process. When a provider uses the *CMS-1500* claim form or its electronic equivalent to submit claims for valid FQHC and RHC encounters, those claims must contain the T1015 and the CPT/HCPCS codes for the services rendered.

> *Note:* *Providers should refer to the IHCP Companion Guides at indianamedicaid.com for specific information about electronic claim transaction requirements to be used with the 837 implementation guides. For information about submitting claims via the Portal, see the Provider Healthcare Portal module. For general billing instructions, see the Claim Submission and Processing module.*

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

The IHCP allows reimbursement for only one encounter code (T1015) per IHCP member, per billing provider, per day, unless the primary diagnosis code differs for additional encounters. Multiple encounter claims from an FQHC or RHC for a member on the same date of service that do not include a different primary diagnosis code are denied for EOB 5000 or 5001 – *This is a duplicate of another claim*.

FQHCs and RHCs must strictly follow proper billing guidelines when submitting multiple diagnosis codes on a single claim. Diagnosis codes must be listed according to their importance, with the first code being the *primary diagnosis* – that is, the one that most strongly supports the medical necessity of the service:

- The diagnosis code submitted in field 21a on the *CMS-1500* claim form is considered the primary diagnosis for determining duplicate claims.
- In the Portal, the first code entered in the Diagnosis Codes field is the primary diagnosis.
- For 837P electronic transactions, the first diagnosis code entered in the Loop 2300 HI segment (H101) is the primary diagnosis.

For services provided at FQHCs or RHCs that are not valid encounters with the appropriate provider, such as injections performed by a nurse without a corresponding visit to satisfy the valid encounter definition, providers should instead reflect the services in the facility's cost report submitted to Myers and Stauffer.

Third-Party Liability Considerations

All third-party liability (TPL), patient or waiver liability, and copayments will apply, as appropriate, to FQHC and RHC services. Allowable Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and pregnancy services provided during an encounter and appropriately billed bypass TPL. See the *Prenatal and Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance* table on the *Code Sets* page at indianamedicaid.com.

The IHCP applies previous TPL payments at the detail level. The IHCP excludes all Medicare crossover claims from the PPS logic, as well as the crossover reimbursement methodology, and continues to pay coinsurance or copayment and deductible amounts. See the *Third Party Liability* module for general information about TPL.

Medicare Processed Claims Submitted to the IHCP by the Provider

Providers can submit FQHC and RHC claims for dually eligible members either as an **institutional** claim (using the *UB-04* claim form or electronic equivalent) or as a **professional** claim (using the *CMS-1500* claim form or electronic equivalent). FQHC and RHC claims submitted as professional claims must contain the T1015 encounter code and the CPT or HCPCS codes for the services rendered.

FQHCs and independent RHCs submit claims to the Medicare intermediary using the institutional claim type. However, FQHCs and RHCs can use the professional claim type to submit Medicare-processed claims by that did not automatically cross over to the IHCP, including claims allowed by Medicare that failed to cross over as well as Medicare-denied claims. If Medicare denied the claim, providers must attach the Explanation of Medicare Benefits (EOMB)

All crossover claims must show Medicare as the previous payer and must include Medicare-paid amount (actual dollars received from Medicare) as well as Medicare deductible and coinsurance or copayment information. Crossover claims submitted as institutional claims must contain value codes A1 and A2 to reflect the Medicare deductible and coinsurance or copayment amount. In the case of outpatient and professional (medical) crossover claims, providers must also submit itemized Medicare paid amount, deductible, and copayment or coinsurance information at the detail level. When submitting outpatient or professional crossover claims on paper claim forms, billers must complete the *IHCP TPL/Medicare Special Attachment Form*, available on the *Forms* page at indianamedicaid.com, and include it with the *UB-04* or *CMS-1500* claim form. For additional information about Medicare crossover billing, see the *Claim Submission and Processing* module.

Provider Enrollment Considerations

All physicians associated with the clinic must have an individual IHCP-issued Provider ID. Providers must also report their National Provider Identifier (NPI) to the IHCP. The Provider IDs and NPIs must be linked to the FQHC or RHC.

> *Note: Physician assistants **cannot** obtain an IHCP rendering provider NPI. Providers must use the supervising practitioner's NPI to submit claims for services rendered by these practitioners.*

When a provider is no longer associated with the FQHC or RHC, the clinic must notify the Provider Enrollment Unit in writing or via the *Provider Maintenance* page of the Provider Healthcare Portal so that the clinic provider information on file is current.

If the CMS notifies an FQHC or RHC that the FQHC or RHC status has been terminated, the provider must send a copy of the termination to the ISDH, which then forwards it to the Provider Enrollment Unit. The provider must enroll as a medical clinic until FQHC or RHC status is reinstated. Failure to do so will result in disenrollment as a provider and loss of any managed care members assigned to primary medical providers (PMPs) linked to that location.

See the *Provider Enrollment* module for more information about enrolling as an IHCP provider and updating provider information on file.

Managed Care Considerations

FQHCs and RHCs can participate with a managed care entity (MCE). The MCE provider contract must specify the contractual arrangements to ensure that the FQHC or RHC is reimbursed for services. Claims for members in a managed care plan such as Hoosier Care Connect, Hoosier Healthwise, or the Healthy Indiana Plan (HIP) must be billed in the manner applicable to the specific MCE, and submitted to the MCE for processing. FQHC and RHC providers should use CPT codes to bill claims for members in managed care. Do not include the T1015 encounter code on these claims.

Myers and Stauffer reconciles all managed care claims to the provider-specific PPS rate and makes annual settlements. Providers may submit requests for supplemental payment to Myers and Stauffer. The MCEs must also provide data related to annual reconciliations to Myers and Stauffer.

> *Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide available at indianamedicaid.com.*

Service Coverage for FQHCs and RHCs

IHCP reimbursement is available to FQHCs and RHCs for services provided by the following providers:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical psychologist
- Clinical social worker
- Dentist

- Dental hygienist
- Podiatrist
- Optometrist
- Chiropractor

The IHCP also reimburses FQHCs and RHCs for services – and supplies incidental to such services – that the IHCP would otherwise cover if furnished by a physician or incidental to a physician's services. Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling and dispensing prescriptions, or providing optician services do not constitute encounters. Providers can include these services in the encounter reimbursement when performed in conjunction with the office visit to a valid provider. The IHCP does not reimburse for these services through claim submission if performed without a visit with a valid provider.

FQHCs and RHCs can provide preventive services and EPSDT/HealthWatch services. For more information, see the *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch* module.

The IHCP reimburses FQHCs and RHCs for services to homebound individuals only in the case of FQHCs and RHCs located in areas with shortages of home health agencies, as determined by the FSSA. The IHCP considers any other ambulatory service included in the Medicaid state plan to be a covered FQHC service if the FQHC offers such a service. FQHC services are defined the same as services provided by RHCs.

FQHCs and RHCs should contact Myers and Stauffer for information about cost reports and interim cost settlements.

Telemedicine Services

For information on telemedicine services provided by FQHCs and RHCs, see the *Telemedicine and Telehealth Services* module.

Hospital Services

The IHCP reimburses claims submitted with place of service codes 19 through 26 (urgent care facilities, on- and off-campus outpatient hospitals, inpatient hospitals, emergency rooms, ambulatory surgical centers, birthing centers, and military treatment facilities) at the current reimbursement rate for each specific CPT or HCPCS code. It is not necessary for providers to include the T1015 encounter code on claims with place of service codes 19 through 26. The IHCP considers these services non-FQHC/RHC services provided by the valid provider but in a setting other than an FQHC or RHC.

Dental Services

Providers should bill claims for dental services provided at an FQHC or RHC as a dental claim (*ADA 2006* paper claim form, Portal dental claim, or 837D transaction) using Current Dental Terminology (CDT®[2]) codes. Do not include the T1015 encounter code on dental claims. Myers and Stauffer makes settlements and reconciles dental claims to the provider-specific PPS rate through annual reconciliations. The reconciliations continue until *Core*MMIS is adapted to the PPS methodology.

See the *Claim Submission and Processing* module for information about completing the *ADA 2006* dental claim form and see the *Provider Healthcare Portal* module for information about submitting dental claims via the Portal. See the *Dental Services* module for information about IHCP dental coverage, billing, and reimbursement.

[2] *CDT copyright 2016 American Dental Association. All rights reserved.*