REIMBURSEMENT

Reimbursement for federally qualified health center (FQHC) services is made for those primary care services provided to Medicaid recipients by enrolled FQHC providers. These services are described in Section 22.1 – Covered Services of this manual chapter. FQHCs are reimbursed for Medicaid covered services under an all-inclusive Prospective Payment System (PPS) as specified under Section 1902(bb) of the Social Security Act.

Payments specified as the PPS rates are all inclusive of professional, technical and facility charges, including evaluation and management, routine surgical and therapeutic procedures and diagnostic testing (including laboratory/pathology and radiology) capable of being performed on site at the FQHC and must be billed by utilizing the facilities' provider identification number (ID) and Tax Identification Number (TIN).

- Laboratory/pathology, radiology and medications administered are not separately reimbursable. To the extent that the provider has the capabilities to provide these services and has historically provided these services, the FQHC shall continue to provide such services; and

- The bundling of therapeutic and diagnostic testing services in the PPS rate is not meant to imply that the FQHC shall vend or refer out such ancillary services to other providers merely for the purpose of maximizing reimbursement.

Services and supplies incidental to a service visit include those services commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications, supplies used in a patient service visit. Services provided incidental to a service visit must be furnished by an employee and must be furnished under the direct supervision of an FQHC health care practitioner, meaning the health care practitioner must be immediately available when necessary, even if by telephone.

NOTE: Professional services performed in the FQHC will be subject to recoupment if billed under a physician/practitioner's individual Medicaid ID number.

Rates

Determination of Rate

Payments for Medicaid covered services will be made under a PPS and paid on a per visit basis.

For an FQHC which enrolls and receives approval to operate, the facility's initial PPS per visit rate will be the weighted average cost payment rate per encounter for all FQHCs.

Adjustment of Rate

PPS rates for primary care services are adjusted effective July 1 of the state fiscal year by the published Medicare Economic Index(MEI) as prescribed in Section 1902(bb)(3)(A) of the Social Security Act.

PPS rates are adjusted to take into account any change (increase or decrease) in the scope of services furnished by the FQHC. A change in scope is an addition, removal or relocation of service sites and the addition or deletion of specialty and non-primary services that were not included in the base line rate calculation. The relocation of a site that does not impact the budget, the services provided and the number of patients served, or the number and type of providers available does not require a change in scope request for such relocation.

The FQHC is responsible for notifying the Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), in writing, of any increases or decreases in the scope. If the change is for the inclusion of an additional service or deletion of an existing service/site, the FQHC shall include the following in the notification:

- The current approved organization budget and a budget for the addition or deletion of services/sites;
- A detailed request for change in scope;
- A cost report for the years preceding the change in scope; and
- An assessment of the impact on total visits and Medicaid visits.

A new interim rate will be established based upon the reasonable allowed cost contained in the budget information. The final PPS rate will be calculated using the first two years of audited Medicaid cost reports which include the change in scope.

Out of State/Trade Area FQHC

An out of state FQHC in the trade area will be reimbursed the lesser of the Louisiana state-wide average or the PPS rate assigned to that FQHC in its state's location.

Notice of Rate Setting

BHSF will send written notice to the center notifying the center of the reimbursement rate per encounter and the methodology used to establish the rate.

BHSF, or its contracted auditing agency, will reconcile the initial PPS rates to the final audited PPS rates and inform the center of the rate determination and any reconciling amounts owed to the center or due from the center.

Appeals

FQHCs requesting to appeal the established PPS rate must submit their request in writing. (See Appendix A for contact information).

Cost Report Submission

To receive a PPS rate adjustment, FQHCs must submit cost reports for Health Resources and Services Administration (HRSA) approved changes in scope of service. **A cost report must be submitted prior to the consideration for PPS rate adjustments.** A HRSA approved change in scope can include: addition, removal or relocation of services sites, or the addition or deletion of specialty and non-primary services that were not included in the baseline rate calculation.

An interim rate will be set based on the initial cost report and effective the next state fiscal year. The final PPS rate will be determined using the first two years of audited Medicaid cost reports, which must include documentation of the change in scope. **Cost reports will not be accepted for rate changes without a HRSA approved change in scope of service**.

NOTE: All HRSA approved changes in scope of service must be reported to the Department using the completed FQHC Services Facility Survey. (See Appendix E of this manual chapter).

Audits

All cost reports are subject to audit, including desk audits and field audits.

Encounter Visits

An FQHC provider will be reimbursed for only one medical (inclusive of mental health services) encounter and one dental encounter per day. Core service encounters with more than one health professional, and multiple encounters with the same health profession, that take place on the same date of service, at a single location, constitute a single visit, and are limited to one encounter per day except when one of the following conditions exists:

- After the first encounter, the recipient suffers illness or injury requiring additional diagnosis or treatment.
- The recipient has a medical visit or dental visit on the same day. Behavioral health benefits are subject to the requirements outlined Section 22:1 Covered Services of this provider manual.

Services and supplies that are furnished by FQHC staff and incidental to an FQHC professional service as commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications and supplies used in a patient service visit are considered part of the FQHC service.

Fluoride varnish applications shall only be reimbursed to the FQHC when performed on the same date of service as an office visit or preventative screening. Separate encounters for fluoride varnish services are not permitted and the application of fluoride varnish does not constitute an encounter visit.

Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician**.**

Payment for Adjunct Services

Reimbursement will be made for adjunct services in addition to the encounter rate paid for professional services when these services are rendered during the evening, weekend or holiday hours as outlined in the *Current Procedural Terminology* (CPT) manual under "Special Services, Procedures and Reports".

To facilitate recipient access to services during non-typical hours and to reduce the inappropriate use of the hospital emergency department, the reimbursement provided by use of the adjunct codes is intended to assist with covering the additional administrative costs associated with staffing

during these times. Providers are not to alter their existing business hours for the purpose of maximizing reimbursement.

The reimbursement is a flat fee in addition to the reimbursement for the associated encounter. Reimbursement for adjunct services are only billable for services rendered on weekends, state legal holidays, and between the hours of 5 p.m. and 8 a.m., Monday through Friday. Documentation must include the time the services were rendered.

NOTE: Payment is not allowed when the encounter is for dental services only.

Services with Alternative Payment Methodology

FQHCs will receive reimbursement outside of their prospective payment system rate for the below Medicaid covered services.

Long Acting Reversible Contraceptives (LARCs)

Reimbursement for these services will be the lesser of the Medicaid fee for service rate on file or the actual acquisition cost (AAC), for entities participating in the 340B program. The rates for LARCs are located on the Durable Medical Equipment fee schedule on www.lamedicaid.com.

FQHC providers must submit the medical encounter and required detail line(s) for services provided to the recipient on the date of service according to current policy. The procedure code for the appropriate LARC insertion and LARC must be included in the detail lines of the claim. Detail lines for the LARC and LARC insertion cannot be the only detail lines on the claim or the claim will deny. The procedure code for the services listed will pay accordingly. All other detail lines on the claim will pay at zero.

Billing

Medical/Behavioral Encounters

Medical/behavioral health services provided in FQHCs are reimbursed as encounters. These encounter visits must be billed on a CMS-1500 using procedure code T1015. The encounter reimbursement includes all services provided to the recipient on that date of service and any services on a subsequent day incidental to the original encounter visit. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines.

When behavioral health services are the only services provided during an encounter, and are administered by a licensed clinical social worker or a clinical psychologist, the FQHC provider identification number must be placed as both the billing and attending provider with the appropriate modifiers and detail line procedure codes on the claim.

A visit to pick up a prescription or a referral is not considered a billable encounter. Lab or x-ray services with no "face-to-face" encounter with a covered FQHC provider do not constitute an FQHC visit and will not be reimbursed separately as they are part of the original medical encounter which warranted these additional services.

If a covered service is provided via an interactive audio and video telecommunications system (telemedicine), it must be identified on the claims form by appending the Health Insurance Portability and Accountability Act (HIPAA) 1996 complaint modifier "GT" to the appropriate procedure code.

For obstetrical services, providers must bill the encounter code T1015 with modifier TH and all services performed on that date of service.

NOTE: Professional services not covered through the Professional Services Program are not covered through the FQHC Program.

Behavioral Health/Psychiatric Services

Louisiana Medicaid reimburses professional service providers for select procedure codes specific to psychiatric services delivered in the office or other outpatient facility setting. This policy is applicable to physician services in the Professional Services program and mental health services provided in FQHCs. FQHC providers should enter the appropriate psychiatric procedure codes as encounter detail lines when submitting claims for the following services:

- Psychiatric diagnostic or evaluative interview procedures;
  NOTE: Procedure codes are reimbursable once per 365 days per attending provider.

- Psychiatric therapeutic procedures; and

- Psychological testing.

Psychological testing is reimbursable once per 365 days per attending provider. All applicable units of services related to this procedure code should be billed on one date of service and the units should not be divided among multiple dates of services or claim lines.

NOTE: Should nationally approved changes occur to CPT codes at a future date that relate to psychiatric services, providers are to follow the most accurate coding available for covered services for that particular date of service, unless otherwise directed.

In order to receive reimbursement from Louisiana Medicaid for behavioral health services, the FQHC's HRSA approval must include behavioral health services as a part of the clinic's scope of service. In addition, the FQHC must notify LDH by completing a new FQHC Facility Survey (see Appendix E) and submitting it to the Department. The FQHC is not required to obtain a Behavioral Health Service provider (BHSP) license from LDH Health Standards. A FQHC will be reimbursed the all-inclusive PPS rate for these services and must follow FQHC rules, policies, and manuals when billing. Practitioners who meet the above criteria can provide behavioral health services in the FQHC if they are one of the below:

- Physicians with a Psychiatric Specialty;
- Nurse Practitioners or Clinical Nurse Specialists with a Psychiatric Specialty;
- Licensed Clinical Social Workers; or
- Clinical Psychologists.

Physicians with a Psychiatric Specialty

The FQHC Medicaid ID number must be listed as the billing provider and the physician's individual Medicaid ID number must be listed as the attending provider on the claim for mental health services rendered by a physician with a psychiatric specialty.

Nurse Practitioners or Clinical Nurse Specialists with a Psychiatric Specialty

The FQHC Medicaid ID number must be listed as the billing provider and the nurse practitioner or clinical nurse specialist's individual Medicaid ID number must be listed as the attending provider on the claim for mental health services rendered by a nurse practitioner or clinical nurse specialist.

Licensed Clinical Social Workers

The FQHC Medicaid ID number is listed as the billing and attending provider on the claim for mental health services provided in an FQHC by a licensed clinical social worker. If the service provided is one of the procedure codes listed above, the AJ modifier is appended to the procedure code in the detail line of the claim.

Clinical Psychologist

The FQHC Medicaid ID number must be listed as the billing and attending provider on the claim for mental health services provided in an FQHC by a clinical psychologist. If the service provided is one of the procedure codes listed above, the AH modifier is appended to the procedure code in the detail line of the claim.

NOTE: Only behavioral health/psychiatric service practitioners in the above categories are allowed to bill using an FQHC Medicaid ID number.

If the FQHC provides specialized mental health rehabilitation services, i.e. community psychiatric support and treatment (CPST), crisis intervention, (CI), and/or psychosocial rehabilitation (PSR) without the service being included in their HRSA scope of service approval or if services are delivered by an individual who is not a psychiatrist, an advanced practice registered nurse (APRN) with psychiatric specialty, a licensed clinical social worker or a licensed clinical psychologist, the entity is required to obtain a BHSP license issued by LDH Health Standards. The entity must enroll as an appropriate Specialized Behavioral Health Service (SBHS) provider, obtain a unique National Provider Identifier (NPI), have an active BHSP license issued by LDH Health Standards and meet qualifications and requirements established in the Medicaid Behavioral Health Services Provider Manual, rules, laws and regulations. The entity must bill using its unique BHSP NPI in accordance with the SBHS Medicaid rules, policies and manuals.

Adjunct Services

FQHC adjunct services should be billed with the T1015 encounter code, the appropriate detail procedure, along with the adjunct service procedure code. The adjunct service procedure code may not be submitted as the only "detail line" for the encounter.

These adjunct codes are reimbursed in addition to the reimbursement for outpatient evaluation and management services when the services are rendered in settings other than hospital emergency departments:

- Between the hours of 5 p.m. and 8 a.m. Monday through Friday;

- On weekends between 12 a.m. Saturday through midnight on Sunday; and
- State proclaimed legal holidays, 12 a.m. through midnight.

Providers are instructed to bill usual and customary charges. (See Appendix A for information on accessing the fee schedule).

Only one of the adjunct codes may be submitted by a billing provider per day. Providers are to select the code that most accurately reflects their situation. Adjunct codes are reported with another code or codes describing the service related to the recipient's visit or encounter. For example:

- If the existing office hours are Monday-Friday 8 a.m. – 5 p.m. and the physician treats the recipient in the office at 7 p.m., then the provider may report the appropriate basic service (Evaluation/Management (E/M) visit code or encounter) and adjunct code.
- If a recipient is seen in the office on Saturday during existing office hours, the provider may report the appropriate basic service (E/M visit code or encounter) and adjunct code.

Documentation in the medical record relative to this reimbursement must include the time that the services were rendered. Should there be a post payment review of claims, providers may be asked to submit documentation regarding the existing office hours during the timeframe being reviewed.

FQHC providers will receive fee-for-service reimbursement for the adjunct service codes separate from, but in addition to, the PPS reimbursement for the associated encounter (T1015).

- For FQHC providers whose services meet the guidelines outlined in this policy:
  - The encounter and required detail line(s) for services provided to the recipient on a date of service should be reported as directed in current FQHC policy.
  - If appropriate, the adjunct services code may also be reported as a detail line, but it may not be submitted as the only "detail line" for an encounter.
  - The adjunct code will be reimbursed fee-for-service in addition to the payment for the encounter.
- The adjunct codes are not reimbursable for dental encounters.

Payments to all providers are subject to post payment review and recover of overpayments.

Early and Periodic Screening, Diagnosis and Treatment Screening Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services must be billed using the 837P Professional format using encounter code T1015 with modifier EP**.**

It will be necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on the appropriate line. If a registered nurse performs the screening, the appropriate procedure code must be entered followed by the modifier TD.

If immunizations are given at the time of the screening, those codes continue to be billed on the CMS-1500, along with encounter code T1015 and modifier EP. All claims billed using the T1015 and modifier EP must include supporting detail procedures. Only a physician doing a screening should bill with no modifier.

Dental Encounters

All dental services must be billed on the 2006 ADA claim form using the encounter code D0999. In addition to the encounter code, providers must list the specific dental services provided by entering the procedure code for each service rendered on subsequent lines. The provider should also include zero or usual/customary charges for each service provided.

The Recipient Eligibility Verification System (REVS) or the Medicaid Eligibility Verification System (MEVS) should be used to obtain recipient eligibility information. Providers should keep hardcopy proof of eligibility from MEVS on file. Medicaid eligibility verification is also available on the web. (See Appendix A for web information).

NOTE: The dental encounter, D0999, may be billed on the same date of services as the encounter codes T1015, T1015 TH (OB encounter), and/or T1015 EP **(**EPSDT screening**).**

Medicare/Medicaid Dual Eligible Billing

Medicaid pays the Medicare co-insurance, up to the Medicaid established encounter rate, for recipients who are eligible for Medicare and Medicaid. Providers should first file claims with the regional Medicare fiscal intermediary/carrier, ensuring the recipient's Medicaid ID number is included on the Medicare claim form, before filing with Medicaid.

After the Medicare claim has been processed, then Medicaid should be billed. Providers must bill these claims on the UB92/UB04 and include the Medicare Explanation of Benefits, a copy of the

Medicare claims and put the Medicaid provider number and Medicaid ID number in the appropriate form locators. (See Appendix A for information on where to send the claim).

NOTE: This is the only instance where Louisiana Medicaid may be billed using the UB92/UB04 for FQHC services. Straight Medicaid claims must be processed on the CMS-1500 claim form.

Outpatient Services

For all services rendered at the FQHC, in a nursing home or during home visits, the FQHC provider identification number must be used as the billing provider number in the appropriate place on the CMS 1500 claim form.

Inpatient Services

Physician inpatient services are billed through the physician's individual provider number as the billing provider. Physicians are not allowed to bill through their FQHC group number for inpatient services.