REIMBURSEMENT

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.

Rates

Determination of Rate

To determine the baseline rate for FQHCs enrolled in Louisiana Medicaid prior to January 1, 2001, each center's 1999 and 2000 allowable cost were taken from the FQHC's filed 1999 and 2000 Medicaid cost reports. These costs were totaled and divided by the total number of Medicaid patient visits in the cost report years. The baseline calculation included all Medicaid coverable services provided by the FQHC regardless of existing methods of reimbursement for said services.

For FQHCs beginning operation in 2000 and having only a 2000 cost report available for determining the interim PPS rate, the 2000 allowable cost was divided by the total number of Medicaid patient visits for 2000. Upon receipt of the 2001 cost report, the rate methodology was applied using 2000 and 2001 costs and Medicaid patient visits to determine the baseline rate.

Any FQHC that begins operation on or after October 21, 2004 and enrolls in Louisiana Medicaid will have the statewide weighted average payment rate of all FQHCs established as its baseline rate.

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 BHSF Program Operations Section, 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

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

The Program Operations Section 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 due to/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

Federally Qualified Health Centers are required to file a CMS-222-92 with appropriate addenda within five months of the clinics fiscal year end. Failure to submit a CMS-222-92 by the due date may result in a suspension of Medicaid payments. (See Appendix A for information on where to send cost reports)

A written request for an extension on submission of the CMS-222-92 may be granted if received by the FQHC Program Manager within 30 or more days prior to the due date. No extension will

be granted unless the FQHC provides evidence of extenuating circumstances beyond its control that have caused the report to be submitted late.

Audits

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

Encounter Visits

An FQHC provider is limited to being reimbursed to one medical (inclusive of mental health services) encounter and one dental encounter per day, except when a recipient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

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 is limited to services 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.

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 incident 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 total 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. When this modifier is used, the visit is not counted in the 12 office and other outpatient visit limit for recipients 21 years of age and older.

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. Providers should assist recipients in the management of their limited yearly outpatient visits.

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 (current codes 90801-90802)

- Counts toward the outpatient visit service limit allowed per calendar year for adult recipients (age 21 and older)
- Is reimbursable once per 365 days per attending provider

- Psychiatric Therapeutic Procedures (current code range 90804-90815)
  - Counts toward the outpatient visit service limit allowed per calendar year for adult recipients (age 21 and older)

- Psychological Testing (current code 96101)
  - Does NOT count toward the outpatient visit service limit allowed per calendar year for adult recipients (age 21 and older)
  - Is reimbursable once per 365 days per attending provider
  - All applicable units of service related to this procedure code should be billed on one date of service and should not divide the units among multiple dates of service 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.

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.