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. The final PPS rate will be calculated using the Center's first two years of cost report data.

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 approval by the Bureau of Primary Health Care for the change in scope,
- The current approved organization budget and a budget for the addition or deletion of services/sites, 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 5 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. 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.

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.

KIDMED Screening Services

FQHC KIDMED screening services must be billed using the 837P Professional format including the K3 KIDMED segment or on the revised KM3 form 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, then 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. It will be necessary for providers to indicate the specific dental services provided by entering the

procedure code for each service rendered on subsequent lines. All claims billed using D0999 must include supporting detail procedures.

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 **(**KIDMED 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 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 recipient 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.