FQHC/RHC PPS Medicaid and Medicare Billing – Effective January 1, 2022

In accordance with the Centers for Medicare and Medicaid Services (CMS) – Highmark Wholecare Medicaid and Medicare plans require FQHCs and RHCs to submit qualified visits using established specific payment codes. The FQHC/RHC Medicaid and Medicare Billing Guide is ONLY applicable to those practices who are contracted under an Ancillary Services Agreement with the health plan.

Encounter Definition[1]

Rates are charged for each Encounter. An eligible Encounter is defined as:

A. Medical Service Encounter: An encounter between a medical provider and a patient during which medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Family planning encounters and obstetrical encounters are a subset of medical encounters.

B. Eligible Providers include:

Physician (including Podiatrists) 2. Mid-level Practitioners:
CRNP (midwife or a licensed nurse practitioner)
Licensed Physician Assistant
Speech, Physical & Occupational Therapist
Nutritionist (Medicaid)
Audiologist
Case Manager

ALL practitioners MUST come over on the roster and be setup in our credentialing/claims systems PRIOR to rendering service. Refer to the FQHC/RHC Resources webpage: FQHC/RHC Roster Template Instructions and Template. https://www.highmarkwholecare.com/provider/provider-resources/fqhc-rhc-resources

As a reminder, please be sure to include the Group Name and Group NPI# in the equivalent of box 33 provider billing information field on the HCFA form. Remember to include the rendering physician's name in box 31 with the rendering NPI in box 24j.

- PAs/CRNPs CAN NOW bill alone under the Medicaid LOB under their own NPI number.
- ALL FQHCs/RHCs must have a collaborative agreement on file between the physician and extender(s) on staff.
- Medicare CRNPs can bill under their own NPI number.

Medicaid Billing Reference:
FQHC Claim Submission

CMS-1500 Format / Electronic 837P Format

FQHCs and RHCs may submit claims for medical encounters provided to our members on paper CMS 1500 forms, UB or electronic.

- Highmark Wholecare encourages our FQHC/RHC providers to submit physician charges on CMS 1500 forms.

- 837P claim forms. (Refer to our Medicaid Policy and Procedure Manual located under Providers at
- www.HighmarkWholecare.com for information on Timely Filing Guidelines and Electronic Claims Submission.)

FQHC/RHC Medicaid Billing ONLY:
Encounter code T1015 for FQHC/RHC Medicaid billing must be listed in addition to the related fee-for service procedure codes in order for the claim to process. This is essential for services needed to measure the quality of care provided, such as immunization codes and in office labs like Hemoglobin A1c and urine protein tests for diabetics. Total charges for the encounter should be billed with code T1015. Claims submitted with just the T1015 will not be paid.

ALL participating FQHC/RHC are required to bill with the following Place of Service Code.

50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

NOTE: For services rendered at an FQHC or RHC facility, please do not bill with POS 11.

EPSDT Billing Guidelines for FQHCs/RHCs:
An EPSDT screen is complete when codes from each service area required for that age, including the appropriate evaluation and management codes, and appropriate modifiers, are documented in the record and on the claim.

Consult the current Pennsylvania EPSDT Program Periodicity Schedule and Coding Matrix as well as the ACIP Recommended Childhood Immunization Schedule for screening eligibility information and the services required to bill for a complete EPSDT screen. These can be found on the Gateway website under Provider Resources EPSDT.

Highmark Wholecare uses fully automated coding review software. The software programmatically evaluates claim payments in accordance with CPT-4, HCPCS, ICD-10, AMA and CMS guidelines as well as industry standards, medical policy and literature and academic affiliations.

- The claim must include the T1015 in addition to the Visit Codes 99381/99391-99385/99395 and the EP modifier.

- The EPSDT Periodicity is considered compliant when all the Services for the periodicity are completed and listed on the claim in addition to the T code and Visit code.

- Claims will be paid at the provider's EPSDT rate only if the appropriate evaluation and management code and EP modifier are submitted.

- With the exception of the dental component for clinics that do not offer dental services, FQHCs/RHCs may not bill for partial screens. Therefore, all codes for the child's periodicity must be included on the claim.

Childhood Nutrition and Weight Management Services for MA members under 21 years of age. Our company allows for MA Childhood Nutrition and Weight Management Services when billed with the T1015 along with the specific modifiers for participating Medicaid FQHC/RHCs. The MA Childhood Nutrition and Weight Management Services Bulletin allows for reimbursement to FQHCs and RHCs enrolled in the MA Program when the services are medically necessary and rendered to MA beneficiaries under 21 years of age who are experiencing weight management problems. Please refer to the most recent Medical Assistance Bulletin regarding Childhood Nutrition and Weight Management Services from the link below:

https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/MAB2020052603.pdf

A claim shall not be considered a clean claim unless and until it includes all information required including but not limited to, procedure codes for all services rendered during the visit, appropriate place of service codes, and complete diagnosis codes regardless of expected payment.

Refer to the Maternity – Prenatal and Postpartum Care Guide for Maternity/Obstetrical billing instructions

https://www.HighmarkWholecare.com/Portals/0/docs/FQHC_RHC%20Guides/FQHCObstetricalBillingGuide.pdf

Medicare Billing Reference:
RHC Claim Submission
CMS-1500 Format / Electronic 837P Format
FQHCs and RHCs may submit claims for medical encounters provided to our members on paper

CMS 1500 forms, UB or electronic 837P claim forms. (Refer to our Medicaid Policy and Procedure Manual located under Providers at www.HighmarkWholecare.com for information on Timely Filing Guidelines and Electronic Claims Submission.)

FQHC Medicare Billing ONLY: Pages 3-4 for the (5) FQHC Specific Payment G-HCPCS Codes: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM8743.pdf

CMS required HCPCS specific payment codes to be used by FQHCs submitting claims under the PPS Rate for Medicare:
G0466 – FQHC visit, new patient
G0467 – FQHC visit, established patient
G0468 – FQHC visit, IPPE or AWV
G0469 – FQHC visit, mental health, new patient
G0470 – FQHC visit, mental health, established patient
RHC Medicare Billing ONLY: Pages 9-11 RHC Medical Services, Approved Preventive Health Services and Medical Health Services (68) 9 series & G-HCPCS Codes:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9269.pdf

RHC Qualifying Visit List

HCPCS Code	Short Descriptor
92002	Eye exam new patient
92004	Eye exam new patient
92012	Eye exam establish patient
92014	Eye exam&trx estab pt 1/> vst
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
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 assessmnt
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
99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99337	Domicil/r-home visit est 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
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advanc care plan 30 min

Approved Preventive Health Services

HCPCS Code	Short Descriptor
G0101	Ca screen; pelvic/breast exam
G0102*	Prostate ca screening; dre
G0117*	Glaucoma scrn hgh risk direc
G0118*	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
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
Q0091	Obtaining screen pap smear

**Coinsurance and deductible are not waived*

Mental Health Services

HCPCS Code	Short Descriptor
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

Multiple Encounter Submission
Encounters with more than one eligible practitioner and multiple encounters with the same eligible practitioner that take place on the same date, at a single location, and that have the same diagnosis constitute

a single encounter. The following two conditions are recognized for payment of more than one encounter rate on the same day:

- After the first encounter, the member suffers a different illness or injury requiring additional diagnosis or treatment; and
- The patient has a medical visit, a behavioral health visit, or a dental visit on the same day.

The medical necessity of multiple encounters must be clearly documented in the medical record. Providers must exercise caution when billing for multiple encounters on the same day, and such instances are subject to post-payment review to determine the validity and appropriateness of multiple encounters.

Providers may not inappropriately generate multiple encounters by unbundling services that are routinely provided together during a single visit or scheduling multiple patient visits for services that could be performed at a single visit.

Include only one encounter per claim. Claims with more than one encounter listed will be denied.
When billing for more than one encounter per day, submit one claim for each encounter.
On each claim, to indicate it is a separate encounter, enter "unrelated diagnosis" and the time of both visits in field 19 on the 1500 Claim Form or in the Comments field when billing electronically.
Documentation for all encounters must be kept in the member's file.
Department of Health and Human Services Centers for Medicare & Medicare Services Reference:

MLN Matter Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM8743.pdf

MLN Matter Required Billing Updates for Rural Health Clinics https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9269.pdf

HRSA Approval Reminder
If HRSA approves a request for a change in scope of services involving the addition of a service that has never been provided or the discontinuance of an existing service, the FQHC must notify Highmark Wholecare of the change in scope of services within 30 days of the issue date identified in block 1 of HRSA's Notice of Grant Award. Additionally, any interim rate letter(s) received from PA DHS must be forwarded to Highmark Wholecare within 10 days of receipt. These notifications should be directed to the attention of the assigned Highmark Wholecare FQHC/RHC Contracting and Servicing Consultant, while also copying GHPFinanceDHSInbox@HighmarkWholecare.com and GHPContractMonitoringTeam@HighmarkWholecare.com