State of New Mexico
Medical Assistance Program Manual
Supplement

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TO: ALL FEDERALLY QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS, HOSPITAL-BASED RURAL HEALTH CLINICS, AND IHS FEDERALLY QUALIFIED HEALTH CENTERS

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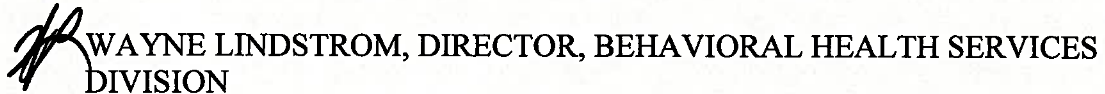
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SUBJECT: BILLING AND PAYMENT TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC), HOSPITAL BASED RURAL HEALTH CLINICS (HB-RHC) AND INDIAN HEALTH SERVICE (IHS) FQHCs

Fee for Service Claims

For the Medicaid Fee-for-Service (FFS) Program, an FQHC must bill all services using the UB format, showing any prior payment on the form even if that prior payment was made by other insurance or Medicare and regardless of whether that prior payment was made using a UB format or a CMS 1500 format claim.

- Medicare allows FQHCs to bill separately for some services that are not included in the Medicare FQHC encounter rate, (including lab services, physician inpatient or offsite visits, and deliveries) using the CMS 1500 format which Medicare then pays at fee schedule rates.

  However, when Medicare sends those cross-over claims to Medicaid, the FFS program does not make payment on those claims because the services included in the Medicaid encounter rate are different than those included in the Medicare encounter rate. Lab and all practitioner visits are included in the FQHC encounter rate.

  Also, one single FQHC encounter with a Medicare recipient can result in more than one claim being paid by Medicare. When those multiple Medicare paid claims cross over to Medicaid for the co-insurance and deductible payment, payment cannot be made on each one.

- Until the Medicaid FFS program is able to more closely parallel the Medicare program, the FFS program must require the FQHC to always bill the encounter using the UB format, listing any payments from Medicare or any other payer source. FFS then pays the full FQHC encounter rate less all prior payments. If the FQHC has already received more from Medicare than the FQHC encounter rate, the payment made is zero.

- An exception is made for long acting reversible contraceptives (LARC). Those items are paid in addition to the FQHC encounter rate since the FQHC encounter rate is not sufficient to cover the cost of those items which may be as much as $500 to $700, or more.

  Further information on paying for LARC using the revenue code 0636, allowed procedure codes and examples of NDC codes, refer to the FQHC Provider Supplement at:

  http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/Supplement%2016-09.pdf

  The LARC item would typically be billed on a line of the UB format on which the encounter is billed.

Managed Care Organizations and FQHC Claims

For MCOs paying FQHCs, some variations from the FFS method are allowed because MCOs have more flexibility than the current FFS method. Also, an MCO must identify and manage certain services using the claim formats that are best for reporting those services:

1. **DENTAL:**
   Every MCO should already have in place, the ability for an FQHC to bill dental services using the ADA dental claim form. Payment is made at the FQHC encounter rate unless the dental service is on the list of dental codes that are to be paid at the fee schedule rate because of the high cost of the dental service.

   These dental codes are:

Dentures:	D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214
Crowns:	D2751, D2752, D2791, D2792

   Effective dates: This has been in place since 2014.

   Other Applicability:

   RHC/HB-RHC
   This provision is not applicable to Rural Health Clinics (RHCs) and Hospital Based Rural Health Clinics (HB-RHCs) because they enroll separately as Rural Health dental clinics and are paid at dental fee schedule rates.

IHS
This provision is not applicable to IHS or Tribal 638 providers because they bill revenue code 0512 and are paid at OMB rates for dental services.

2. **BEHAVIORAL HEALTH:**
Most "Specialized BH Services" are services that are typically provided through a Specialized Behavioral Health entity; that is, a Behavioral Health Agency, a Community Mental Health Center, or a Core Service Agency. These services include:

- Applied Behavioral Analysis (ABA) for treating autism spectrum disorders. The FQHC must be specifically approved as a Stage 1, 2, or 3 ABA provider. The individuals rendering the service must also be enrolled specifically as an ABA autism evaluation practitioner, a behavior analyst, or a behavior technician.

- Assertive Community Treatment (ACT)
The FQHC must have a letter from HSD/BHSD or HSD/MAD approving them for ACT.

- Behavior Management Skills Development (BMS)
The FQHC must be certified by CYFD to provide BMS services.

- Comprehensive Community Support Services (CCSS)
The FQHC must either be licensed as a Community Mental Health Center or designated by HSD/BHSD as also being a Core Service Agency (CSA) and the recipient must be part of the CCSS target population.

- Day Treatment (DT)
The FQHC must be certified by CYFD for Day Treatment.

- Intensive Outpatient Program (IOP)
The FQHC must have applied and have been approved as an IOP provider.

- Multi-Systemic Therapy (MST)
The FQHC must be licensed by MST Inc. and follow specific fidelity models, and have the documentation approved by MAD provider enrollment.

- Psychosocial Rehabilitation Services (PSR)
The FQHC must either be licensed as a Community Mental Health Center or designated by HSD/BHSD as also being a Core Service Agency (CSA) and the recipient must be part of the PSR target population.

The program rules for Behavioral Health are being reviewed and there will be changes. The following website may be helpful in the meantime:

http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/15-01%20BHOCR.pdf

When the requirements for providing these services are met, including necessary licensing when required as a CMHC or a designation as a CSA, an FQHC can be authorized to provide these services under its FQHC provider type. Many FQHCs began providing some of these services as other non-FQHC providers discontinued their operations in New Mexico.

These specialized behavioral health services are different than the typical behavioral health evaluations, therapies, and group therapies rendered by an individual provider or professional group. (Note that for "non-specialized services" such as the typical evaluation and therapy, which is not one of the specialized behavioral health services listed above, FQHCs bill using the UB format as an FQHC encounter, using revenue code 0919 and are paid at the FQHC encounter rate.)

Other Applicability:

RHC/HB-RHC
Not applicable to Rural Health Clinics (RHCs) and Hospital Based Rural Health Clinics (HB-RHCs). When a RHC or HB-RHC qualifies to render any of the Specialized Behavioral Health Services, they obtain a separate Medicaid provider for their Specialized Behavioral Health Services and enroll separately as a BHA, CMHC, or CSA, as appropriate. These Specialized Behavioral Health Services are not part of the core services for these types of providers and are therefore not paid at their encounter rates. Rather, the negotiated MCO fee schedule or Medicaid FFS schedule rates apply.

IHS
IHS or Tribal 638 providers are paid at OMB rates, unless a rate higher than OMB rates is negotiated.

MCOs paying FQHCs for Specialized Behavioral Health Services:

The specialized behavioral health services are best identified using the CMS 1500 format and corresponding 837-P electronic transactions. Therefore, the FQHC must bill for the specialized BH services to MCOs using the CMS 1500 format and only when they are approved to provide specific specialized behavioral health services. Using the CMS 1500 format permits the MCO to determine the utilization of services and manage the qualifications of the provider.

The FQHC is entitled to, at a minimum, the FFS FQHC encounter rate. However, the MCO and the FQHC may negotiate a different rate for each Specialized BH Service. For example, the FQHC rate for IOP does not need to be the same as for Day Treatment.

Effective dates: January 1, 2017.

For dates of service prior to January 1, 2017, if the FQHC and MCO had an agreement to pay specialized behavioral health services at other rates, or if fee schedule rates were paid because the BH services were not rendered within the FQHC facility during a transitional phase, those payments may stand as made.

If an MCO has not paid an FQHC for these services and is awaiting instructions, these instructions are to apply retroactively to when the FQHC began to render the Specialized BH Services.

BH Residential and Treatment Foster Care Services:

Note that under federal rules the following providers and services are not FQHC core services and, therefore, are not paid at FQHC encounter rates:

- Accredited Residential Treatment Centers (ARTCs)
- Residential Treatment Centers (RTCs)
- Group Homes
- Treatment Foster Care (TFC)

To provide any of the above services, the FQHC must enroll as a separate provider for each of these types of services and be paid at the rates for those services, not FQHC encounter rates.

This is also true for RHCs, HB-RHCs, IHS and Tribal 638 providers. However, the rules also allow for the IHS and Tribal 638 rates to be negotiated with MAD when provider cost issues make it appropriate to do so.

Effective dates:
This is already in place. To the extent that MAD is aware, the FQHC providers who render these types of services are already appropriately enrolled.

Suboxone Induction:

Suboxone Induction for which the fee schedule rate is $300 is also to be paid at the fee schedule rate (or other negotiated rate) rather than the FQHC encounter rate if the FQHC provides that service. However, if they render an additional separate physical or behavioral health service (in addition to the Suboxone induction) they may also bill their encounter rate.

Other Applicability:

<u>RHC/HB-RHC</u>
If an RHC or HB-RHC renders this service, it is paid the fee schedule rate rather than the encounter rate. However, if they render an additional separate physical or behavioral health service (in addition to the Suboxone induction) they may also bill their encounter rate.

IHS
Not applicable to IHS or Tribal 638 providers because they are still paid the OMB rate.

Effective date: January 1, 2017
MAD is not aware that either IHS, Tribal 638 providers, RHCs or HB-RHCs have been providing this service in the past. But should they start providing this service, these instructions will apply.

3. **OUT OF CLINIC VISITS AND INPATIENT HOSPITAL VISITS:**
When the practitioner leaves the FQHC to see a recipient in a different setting, such as the home, a nursing facility, or a hospital, the FQHC is still to be paid the encounter rate.

However, because of the billing expectations of other insurers, FQHCs may be required to bill these services to the primary payer using a CMS 1500 format with their usual and customary charge amount as the billed charge.

Other than Medicaid and Medicare, other payers do not typically reimburse any services at FQHC encounter rates. When prior payment from an insurance entity has been made to the FQHC using the CMS 1500 claim format, the FQHC may use either the UB or CMS 1500 format when billing the MCO.

The MCO must allow for the fact that the EOB accompanying an FQHC claim with a prior payment may not match the claim form or the billed amount that the FQHC is submitting for payment of the encounter rate. The FQHC must follow the prior payer's instructions for billing which may mean billing usual and customary charges rather than encounter rates, and using a format other than the CMS 1500.

More information on paying Medicare cross-over claims will be addressed separately in a document specifically for that topic.

See item 5, regarding the need to still limit payment to one encounter payment per day, unless otherwise allowed.

Effective dates: January 1, 2017.

From looking at encounter data submitted to MAD, most if not all MCOs have been making payments to FQHCs on CMS 1500 and UB claim formats. The instructions above simply recognize that is going to happen. The MAD OmniCaid system will be changed as necessary to assure that encounters can be appropriately processed including when FQHC payments were submitted as encounters prior to January 1, 2017.

Other Applicability:
RHCs and HB-RHC are already paid at their encounter rates for inpatient and out of clinic visits.

IHS and Tribal 638 providers are already paid at OMB rate for the out of clinic services when the service is provided on Indian land. The inpatient visits are already paid at fee schedule rates, separately from the OMB rate for the inpatient facility.

4. **PRENATAL CARE, POSTPARTUM CARE, AND DELIVERIES:**
An FQHC bills the prenatal care and postpartum visits as encounters and is paid the encounter rate.

However, they may bill the appropriate "delivery-only" code using the CMS 1500 format and are to be paid the fee schedule rates for that service. These delivery codes, and other potentially occurring services accompanying the delivery, are codes 59409, 59412, 59414, 59514, 59525, 59612, and 59620. The reason that the codes billed must only be for the appropriate delivery services is because using the full global maternity service codes would be inaccurate since the prenatal and postpartum visits have been or will be billed as the encounter occurred and thus would result in an overpayment to the FQHC.

Effective dates:
This standard for billing prenatal and postpartum care and payment is not new and should already be in place.

Payment for the delivery according to the above standards for billing and payment should be in place by January 1, 2017.

For dates of service prior to January 1, 2017, if the FQHC had been billing and/or receiving payment for the delivery at the FQHC encounter rate, that payment may stand as made.

If the FQHC had been billing and/or receiving payment for the delivery at the fee schedule rate, the payment may stand as made.

Other Applicability:

<u>RHC/HB-RHC</u>
RHCs and HB-RHC should begin to be paid the fee schedule rate for deliveries as described above.

<u>IHS</u>
No change is required for IHS or Tribal 638 providers because they are already able to bill for the delivery service in addition to the inpatient facility OMB rate.

5. **PAYING MORE THAN ONE ENCOUNTER ON A SINGLE DATE OF SERVICE**
It is very important that the MCO edit the claims to ensure that no more than one encounter rate is paid per day unless the recipient goes to the FQHC more than once in a day with a different diagnosis, or had two distinct types of visits such as:

- A physical health visit and a dental visit on the same day.

- A physical health visit and a separate behavioral health service provided by a different provider on the same day.
- More than one distinct Specialized Behavioral Health service which does not otherwise overlap or is prohibited from being billed in conjunction with another Specialized BH Service per the NMAC for Specialized Behavioral Health Services.

One reason to assure that not more than one encounter rate is paid when there has been just one recipient encounter is to protect the FQHC. If the MCO were to pay an encounter rate on a Medicare cross over claim that included only lab services, and then pay a second encounter rate on a Medicare cross over claim for the medical facility service, it would result in an over payment to the FQHC.

In the past when an FQHC has been paid for more than one encounter rate for the day when there was really only one recipient encounter, payments have been recouped.

When duplicate payments have occurred over a period of years, and the overpayment is then detected, it is possible the recovery amount from the provider would exceed the FQHCs ability to pay back the overpayment. So despite the fact that there may be one or more cross over claims paid to the FQHC for one encounter due to Medicare "unbundling" some services from the Medicare encounter rate, the MCO must not pay for more than one encounter. This is most likely to occur when there is a cross over for laboratory services and then one for the medical facility visit.

Effective dates: January 1, 2017

From looking at encounter data submitted to MAD, most if not all MCOs have been making payments to FQHCs using CMS 1500 and UB claim formats with other insurance or Medicare as a prior payer. The MAD OmniCaid system will be changed as necessary to assure that encounters can be appropriately processed including FQHC payments that have been submitted as encounters prior to January 1, 2017.