

Billing Procedures

The following is specific to RHCs/FQHCs. In addition, providers should refer to the Billing Procedures chapter in the *General Information for Providers* manual.

Claim Forms

RHC and FQHC services must be billed either electronically or on a UB-04 claim form. UB-04 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Member Cost Sharing (ARM 37.85.204 and 37.85.402)

See the *General Information for Providers* manual for information on member cost share for RHC and FQHC services.

Coding for RHCs/FQHCs

The following is specific to RHCs/FQHCs. See the *General Information for Providers* manual for additional information.

RHCs and FQHCs must use the following revenue codes as specified by the Department. Check with Provider Relations to make sure they are valid for your facility. If invalid for your clinic, the use of these revenue codes will result in non-payment.

- B 512 Dental
- B 521 RHC/FQHC clinic visit
- B 522 RHC/FQHC home visit
- B 524 Visit by RHC/FQHC practitioner to a member in an covered Part A stay at a skilled nursing facility
- B 525 Visit by RHC/FQHC practitioner to a member in a skilled nursing facility (not a covered Part A stay) or nursing facility or intermediate care facility for the mentally retarded or other residential facility
- B 527 RHC/FQHC visiting nurse services to a member's home when in a home health shortage area
- B 528 Visit by an RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)
- B 636 HMK vaccine reimbursements
- B 771 HMK non-visit vaccine administration fee
- B 780 Telehealth originating site
- B 900 Mental health visits

Number of Lines on Claim

Clinic claims are reimbursed using an all-inclusive rate of payment per visit. Only one line per claim will receive payment, except in the case of HMK vaccination vaccine and administration fees, which can pay per line. See page 2.6 for information on HMK vaccination billing.

Multiple Services on Same Date (ARM 37.86.4402)

A clinic visit is defined as a face-to-face encounter between a clinic patient and a clinic healthcare professional for the purpose of providing clinic core or other ambulatory services or billable incidental services. Encounters with more than one clinic healthcare professional, and multiple encounters with the same clinic healthcare professional, on the same day at a single location constitute a single visit except when one of the following exists:

- After the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment; or
- The patient has a medical visit and a mental health visit, or a medical visit and a dental visit, or a mental health visit and a dental visit.

Span Bills

Span billing is not allowed for RHCs and FQHCs. Providers may bill for only one date of service per claim. Spans greater than one date of service in FL 6 will result in payment for one date of service. Reimbursement of other dates of service within the span is not possible until the paid claim is adjusted to reflect one date of service only.

Using Modifiers

When billing on a UB-04, the Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen in FL 44. For example, Code 25680 (treatment of wrist fracture) when done bilaterally is reported as Code 2568050.

Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first.

Service Settings

Clinic services are covered when provided in an outpatient setting including the clinic, other medical facility (including a dental office) or a patient's place of residence. A patient's place of residence may be a nursing facility or other institution used as the patient's home. Clinic services are covered off site as long as the service is normally furnished within the scope of the clinic's professional services. Services provided off site are part of the clinic benefit if the provider has an agree-

ment with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic does not compensate the provider for services provided off site, the clinic may not bill Medicaid for those services.

FQHCs and RHCs must not bill in the hospital setting. FQHC and RHC providers that perform services in a hospital setting must bill the service on a CMS-1500 using their own provider number. Pre- and post-visits at the clinic are billed by the clinic on a UB-04 as a core service.

Other Programs

Healthy Montana Kids (HMK)

The information in this chapter applies to HMK for RHC and FQHC clinic services.

Providers may bill HMK revenue codes 512, 521, 636, 771, and 900. Providers billing for HMK dental services must be enrolled as HMK dental providers.

Since HMK-enrolled children are not entitled to the Vaccines for Children (VFC) program, providers may bill Montana Medicaid for vaccines using revenue code 636 and the vaccine procedure code. If a child receives a physician or mid-level visit, vaccines will be paid and administration fees will bundle with the visit fee and pay at zero. If vaccines are administered without a physician or mid-level visit, providers may also bill for vaccine administration fees using revenue code 771 and vaccine administration procedure codes. An immunization-only visit does not qualify for a visit fee.

For more information, contact BCBSMT at 1-800-447-7828. Additional information regarding HMK is available on the [HMK website](#).

