RFC AND FQHC MANUAL
MARCH 2020

Contents

Revised Provider Manual

About this Manual

This publication takes effect July 1, 2019 and supersedes earlier Montana Medicaid RHC and FQHC manuals.

If you need assistance, please contact Montana Healthcare Programs Provider Relations at 1-800-624-3958.

What has changed?

Subject	Change	Reason for Change
Certified Peer Support Behavioral Health Services	Added a new section regarding fee-for-service reimbursement for Certified Peer Support Behavioral Health Services	Policy change
Visiting Nurses	Removed RHC-only reference	Clarification, per 42 CFR 2416
Requirements for Change in Scope of Service	A change in scope of service must be submitted as prospective or retrospective	Policy change
Establishment of interim and baseline Prospective Payment System (PPS) rate	Two ways to determine interim PPS rate. Payment can be suspended if required documentation is not received to determine baseline PPS rate	Policy change

How can I get necessary Montana Healthcare Programs provider information and documentation??

Visit the Montana Healthcare Programs Provider Information webpage at www.medicaidprovider.mt.gov.

The Montana Healthcare Programs Provider Information webpage is where Montana Healthcare Programs posts provider notices, fee schedules, provider manuals and forms. Most information can be located under the 'Resources by Provider Type' tab. Please note that it is a provider's responsibility to check provider notices and fee schedules on a frequent basis to ensure proper billing.

The Montana Healthcare Programs Provider Information webpage is also where the General Provider Manual is posted, which is the resource for requirements such as telemedicine, Passport, cost share, etc.

RHC and FQHC Reimbursement Methodology

All RHC and FQHC services are reimbursed per encounter. Services eligible for an encounter payment are reimbursed utilizing the facility-specific Prospective Payment System (PPS) rate. The PPS rate is one facility-specific, predetermined rate, regardless of the allowable RHC or FQHC service.

Since RHC and FQHC's are reimbursed at their PPS rate for most services, they do not have their own fee schedule. RHC and FQHC's utilize the Outpatient Prospective Payment System (OPPS) fee schedule for reimbursable codes. The OPPS fee schedule is even used to determine allowable dental codes.

Please note, the OPPS fee schedule is for reference of allowable vs. non-allowable codes only. A code appearing on the OPPS fee schedule does not indicate if the code constitutes as an RHC or FQHC service, or if the code is considered an incident to a core provider encounter.

Certain services are deemed non-RHC or non-FQHC services and are paid at the appropriate fee schedule amount. The department determines which non-FQHC and non-RHC services are eligible for reimbursement outside of PPS reimbursement.

How is the Prospective Payment System (PPS) rate calculated?

Upon enrollment with Montana Healthcare Programs, an RHC or FQHC is issued a temporary PPS rate for two complete fiscal years.

After two complete fiscal years, a permanent baseline PPS rate will be established.

Non-RHC or non-FQHC services reimbursed outside of the PPS reimbursement methodology are not factored into the PPS rate. The list of the services a RHC or FQHC may provide is limited and must be previously approved the department. The list of services that is not calculated into the PPS rate includes:

- Peer support services
- Long Acting Reversable Contraceptives (LARCs)
- Promising Pregnancy Care
- Originating telemedicine site

Establishment of Temporary PPS Rate for New RHC or FQHC (ARM 37.86.4413)

Upon enrolling as a new provider with Montana Healthcare Programs a RHC or FQHC is issued a temporary PPS rate. The temporary PPS rate can be set two ways:

- 100% of the average PPS rate of other RHCs or FQHCs located in the same or adjacent area with a similar caseload
- If there is no RHC or FQHC located in the same or adjacent area with a similar caseload, the temporary PPS rate will be equal to the RHC's or FQHC's total projected allowable costs divided by the total projected allowable visits.

Establishment of Permanent Baseline PPS Rate (ARM 37.86.4413)

Two complete fiscal years after an RHC or FQHC has been enrolled with Montana Healthcare Programs, a permanent baseline PPS rate will be established by the department.

The baseline PPS rates is established using the RHC's or FQHC's first two complete as-filed Medicare cost reports. The cost reports are due six months after the end of the second complete fiscal year.

If the cost reports are not received thirty days prior to the six-month deadline, the department will send notification to the RHC or FQHC advising them payment will be suspended on all Montana Healthcare Programs claims if the cost reports are not received in a timely manner.

Within 90 days from receiving the cost reports (and any additional requested information) the department will calculate the permanent baseline PPS rate and send a letter to the RHC or FQHC.

The permanent baseline PPS rate of newly enrolled RHC or FQHC will be retroactive to the date that the RHC or FQHC was enrolled with Montana Healthcare Programs. A mass adjustment of claims will be submitted for any increase or decrease from the temporary PPS rate.

Can the baseline PPS rate change?

The baseline PPS rate can change two different ways:

1. Annual Medicare Economic Index changes - On the first day of each calendar year, the RHC or FQHC's PPS rate will be adjusted accordingly to factor in the Medicare Economic Index (MEI).
2. Change in scope of service - A change in scope of service can result in an incremental change to the baseline PPS rate; incremental changes can be either positive or negative. The baseline PPS rate may also remain the same after a change in scope of service calculation.

Change in Scope of Service

What is a change in scope of service?

A change in scope of service occurs when a RHC or FQHC has experienced a change in the type, intensity (quantity of labor and materials consumed), duration (length of encounter), or amount of a service.

Prospective change in scope of services – A change the RHC or FQHC plans to implement in the future.

Retrospective change in scope of services – A change which took place in the past.

What calculation is utilized to determine the PPS rate when applying for a change in scope of service?

The department uses the following calculations to determine the amount of an incremental change, if any, when an RHC or FQHC applies for a change in scope of service:

$$A/B = C$$

$$D/E = F$$

$$F-C = IC$$

$$\text{Current PPS rate} + IC = \text{New PPS rate}$$

"A" represents allowable costs before the change in scope of service

“B” represents total visits before the change in scope of service

“C” represents the cost per visit before the change in scope of service

“D” represents allowable costs after the change in scope of service

“E” represents total visits after the change in scope of service

“F” represents cost per visit after the change in scope of service

“IC” represents the incremental change due to the change in scope of service

What are some examples of a change in scope of service?

- The addition or deletion of a service that was not originally calculated into the baseline PPS rate
- The addition or deletion of a covered Medicaid RHC or FQHC service under the State Plan
- A change necessary to maintain compliance with amended state or federal regulations
- A change in applicable technology or medical practices utilized by the RHC or FQHC that is not funded by state or federal funds
- A change in the type of patients served, including but not limited to, populations with HIV/AIDS, with other chronic diseases, homeless, elderly, migrant, or other special populations that require more intensive and frequent care
- A change in operating costs attributable to capital expenditures corresponding to a change in the services provided by the RHC or FQHC
- A change in the provider mix, including but not limited to:
    - A transition from mid-level providers to physicians with a corresponding change in services provided
- The addition or removal of specialty providers with a corresponding change in services provided

What are examples of situations not eligible for a change in scope of service?

- A change in ownership, including acquisition by another healthcare entity, RHC or FQHC
- A change in the number of staff furnishing an existing service
- An increase or decrease in administrative staff

- A change in the number of encounters
- A change in the cost of supplies for existing services
- A change in salaries and benefits not directly related to a change in scope of service
- A change in patient type and/or volume without a corresponding change in the services provided
- Capital expenditures for losses covered by insurance
- A change in office location or office space
- The addition of a new site or removal of an existing site, which offers the same RHC or FQHC services.
- Services paid at a fee-for-service rate
    - Example: Peer support services

How does an RHC or FQHC apply for a Change in Scope of Service?

An RHC or FQHC may apply for a prospective change in scope of service or a retrospective change in scope of service.

All change in scope of service requests must be submitted directly to the department in writing.

An RHC or FQHC must apply for a change in scope of service, even if it will not result in an incremental change to the baseline PPS rate.

What information is required to submit with a Prospective Change in Scope of Service?

The following information must be submitted in order to apply for a prospective change in scope of service:

- A narrative description of each change in scope of service
- The date on which the change in scope of service is scheduled to occur
- A description of each cost center(s) on the cost report that will be affected by the change in scope of service
- The cost report for the fiscal year prior to the year in which the change in scope of service is implemented, which considers the change in scope of service.
    - If a projected cost report cannot be completed, the RHC or FQHC must provide sufficient cost and encounter information to establish a temporary rate

What are the deadlines and effective dates associated with a prospective change in scope of service request?

The completed application must be received no later than 120 days in advance of the prospective change in scope of service to be considered timely.

- For timely applications, the effective date of the temporary PPS rate will be the date that the change in scope of service is implemented

- For untimely applications, the effective date of the temporary PPS rate is the later of:
    - The date that the department receives the RHC or FQHC's completed application materials or
    - The date that the change in scope is implemented

What is a temporary PPS rate?

The department will establish a temporary PPS rate within 90 days from receiving the completed application and notify the RHC or FQHC

Once the change in scope of service is implemented, the RHC or FQHC must notify the department, even if the change is implemented on the scheduled date.

What is required to submit to the department to replace the temporary PPS rate with the permanent baseline PPS rate?

After the fiscal year in which the change in scope of service has ended the RHC or FQHC must supplement its application six months after the close of the RHC or FQHC's fiscal year by submitting the following supplemental materials:

- A narrative description of each change in scope of service, including how the services were provided, both before and after the change
- The date that the change in scope of service was implemented
- The RHC or FQHC's as-filed Medicare cost reports for the fiscal year in which the change in scope of service occurred
- The Uniform Data System reports for the calendar year prior to the change in scope of service, and the calendar year in which the change in scope of service occurred
    - Not applicable to RHCs or Urban FQHCs
- A description of each cost center on the cost report affected by the change in scope of service

- An attestation statement that certifies the accuracy, truth and completeness of the information in the application signed by an officer or administrator of the RHC or FQHC
- Any approved changes in scope of project as defined by the federal Health Resources and Service Administration (HRSA)

What if we are late in submitting our supplemental information?

If the supplemental material is not received thirty days prior to the six-month deadline, the department will send notification to the RHC or FQHC advising them that payment for Montana Healthcare Programs, claims will be suspended if the required documentation is not received in a timely manner.

When will the department calculate the new baseline PPS rate for a prospective change in scope of service?

Once all of the supplemental materials are received, the department will establish a permanent baseline PPS rate and notify the RHC or FQHC of the determination.

What effective date will be issued after the baseline PPS rate has been calculated for a prospective change in scope of service?

The effective date of the baseline PPS rate will be retroactive to the date that the change in scope was implemented.

What happens if the baseline PPS rate is different than the temporary rate?

If it is determined that there was an overpayment or underpayment to the RHC or FQHC, the department will reimburse or recoup the appropriate amount.

How often can an RHC or FQHC submit a retrospective change in scope of service?

An RHC or FQHC may apply for a retrospective change in scope of service once per calendar year.

What effective date will be issued after the baseline PPS rate has been calculated for a retrospective change in scope of service?

The completed application must be received six months after the close of the RHC or FQHC's fiscal year, in order to be receive a timely effective date (see below).

- For timely applications, the effective date of the incremental change to the baseline PPS rate is the beginning of the facility's fiscal year following the retrospective change in scope of service.

- For untimely applications, the effective date of the incremental change to the baseline PPS rate is the date that the department received all required information

What information is required to submit with a retrospective change in scope of service?

The following information must be submitted in order to apply for a retrospective change in scope of services:

- A narrative description of each change in scope of service, including how services were provided before and after the change
- The RHC or FQHC's as-filed Medicare cost reports for the fiscal year prior to the change in scope of service and year in which the change in scope of service occurred
- The Uniform Data System reports for the calendar year prior to the change in scope of service, and the calendar year in which the change in scope of service occurred
    - Does not apply to RHCs or Urban FQHCs
- A description of each cost center on the cost report affected by the change in scope of service
- An attestation statement that certifies the truth, accuracy, and completeness of the information in the application signed by an officer or administrator
- Any approved changes in the scope of project as defined by the Health Resources and Services Administration (HRSA).

When will the Department calculate a new PPS rate for a retrospective change in scope of service?

The department will notify the RHC or FQHC of the determination and any change to the PPS rate within 90 days from receiving the complete application and any requested information.

Claim Forms

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

RHC and FQHC services performed in a hospital setting must be billed on a CMS 1500 claim form using their own provider number.

Please note, services submitted on a CMS 1500 claim form will be paid a fee for service rate, not the PPS rate.

Unless otherwise stated, all paper claims must be mailed to the following address:

Claims
P.O. Box 8000
Helena, MT 59604

Revenue Codes

The following revenue codes are reimbursable when billed by an RHC or FQHC with a valid, allowable procedure code

- 512 - Dental
- 521 - RHC/FQHC clinic visit
- 522 - RHC/FQHC home visit
- 524 - Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a skilled nursing facility
- 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
- 527 - RHC/FQHC visiting nurse services to a member's home when in a home health shortage area
- 528 - Visit by an RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)
- 636 - HMK vaccine reimbursements
- 771 - HMK non-visit vaccine administration fee
- 779 - Clinical Pharmacist Practitioner
- 780 - Telehealth originating site
- 900 - Mental health visits
- 910 – Mental health Peer Support Services
- 911 – Substance Use Disorder Peer Support Services
- 942 - Education
- 944 - Substance Use Disorder
- 969 - Promising Pregnancy Care (Group education session)

Number of Lines on Claim

Only one line per valid revenue code, procedure code and primary diagnosis code will receive reimbursement, with an exception to unbundled fee-for-service codes (examples: peer support services, LARCs, etc.).

Multiple Services on Same Date (ARM 37.86.4402)

A visit is a face-to-face encounter between a patient and a health professional for the purpose of providing RHC or FQHC services.

Reimbursement is available for one encounter per day per eligible member unless it is necessary for the member:

- To be seen by different health professionals with different specialties; or
- To be seen multiple times per day due to unrelated diagnoses

Span Billing

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.

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

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.

RHC and FQHC Limitations

Like all healthcare services received by Medicaid members, RHC and FQHC services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Although, an RHC or FQHC receives a facility-specific Prospective Payment System (PPS) rate for most services they provide, the clinic is still obligated to follow the same limits on amount, scope and duration of services covered by the Medicaid program. For example, if the clinic is providing dental services, the dental program limits still apply, such as an individual dental provider requiring an ABCD certification in order to submit claims to ABCD procedure codes.

As an RHC or FQHC, it is the responsibility of the provider to ensure that they are in compliance with requirements disclosed each program's provider manual.

Each clinic and individual provider rendering the service also must maintain a current Medicaid provider enrollment. The enrollment link can be found at www.medicaidprovider.mt.gov.

Service Settings

Clinic services are covered when provided in outpatient settings including the clinic, other medical facility (including a dental office) or a member's place of residence. A member's place of residence may be a nursing facility or other institution used as the member'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 agreement with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic doesn't compensate the provider for services provided off-site, the clinic may not bill Medicaid for those services.

RHC and FQHC providers who perform services in a hospital setting must bill the service on a CMS-1500 form 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.

Satellite Clinics

If clinic or center services are provided in more than one location, each location is independently considered for approval as an RHC or FQHC Medicaid provider, unless prior approval was granted by the department, to operate both locations under one provider.

Per ARM 37.86.4406, to be considered for operation under one provider number, both sites must share medical staff, office staff or administrative staff.

Clinic Covered Core Services

The following are covered core services in RHCs (R), FQHCs (F), or both (B) and may be billed as a visit when there is a face-to-face encounter with the member:

- B – Physician services
- B – Nurse practitioner, nurse specialist, certified nurse midwife or physician's assistant services
- B – Clinical psychologist, clinical social worker, licensed professional counselor services, and licensed addiction counselor
- B – Dental services
- B – Visiting nurse; all requirements in 42 CFR 2416 must be adhered to
- B – Clinical Pharmacist Practitioner
- F – Preventive primary services; does not include eyeglasses or hearing aids, but does include
  - Perinatal care for high-risk members Tuberculosis testing for high-risk members
  - Risk assessment and initial counseling regarding risks
  - Preventive dental

Services and supplies furnished as incidental to the above providers (by non-core providers such as lab techs, radiologists, LPNs, etc.) are included in the provider's rate but are not billable as a stand-alone visit even if the service is performed on a separate day from the core visit. They include:

- B – Furnished as an incidental, although integral, part of the physician's or mid-level practitioner's professional service (i.e., influenza vaccine/administration)
- B – Service commonly rendered without charge or included in the clinic's claim
- B – Service that is commonly furnished in a physician's office or a clinic

- B – Basic lab services essential to the immediate diagnosis and treatment of the member
- B – Furnished under the direct, personal supervision of a physician, mid-level practitioner, psychologist, or social worker.
- B – In the case of a service, furnished by a member of the clinic's healthcare staff who is an employee of the clinic
- B – Drugs and biologicals that cannot be self-administered
- B – Radiology, including ultrasound
- B – Pharmacist-only visits of any kind
- B – Outreach
- B – Case management
- B – Transportation

Dental Hygienist and Dental Hygienist with limited access permit (LAP) Services

A billable dental encounter includes services performed by dental hygienists under the general supervision of a licensed dentist and by dental hygienists with limited access permit (LAP). LAP hygienists must ensure compliance in accordance with MCA 37-4-405.

Fluoride varnish application only encounters are included in the provider's PPS rate. This service is an incidental to the preventative screening or dental visit and is not billable as a stand-alone visit.

Ambulatory Services

Ambulatory services are services other than core services that would be covered under Montana Healthcare Programs, if provided by an individual or entity other than a clinic in accordance with Medicaid requirements.

Ambulatory services are subject to any applicable limitations on the amount, scope, or duration of services covered by the Medicaid program (e.g., medical necessity criteria).

Many of these services also require Passport referral, and some services for adults may require Department authorization. Please check the appropriate Medicaid manual for specific information concerning these services.

- Respiratory therapy and inhalation therapy services

- Physical therapy services
- Occupational therapy services
- Audiology services
- Dental services
- Mental health services
- Diabetes Prevention Program (Provider must be approved by the Department of Public Health and Safety)

Promising Pregnancy Care (ARM 37.86.4412, 37.86.4501, 37.86.4502, 37.86.4503)

Providers must receive approval from the Department to be eligible for reimbursement. Contact the Program Officer for more information.

The obstetric visit will be reimbursed at the FQHC/RHC PPS rate, and the group educational component will be reimbursed an additional enhanced payment in accordance with the posted fee schedule.

Long Acting Reversible Contraceptive Devices (LARCs)

FQHCs/RHCs are eligible for add-on reimbursement for Long Acting Reversible Contraceptive devices(s) (LARCs). Reimbursement shall be separate from the FQHC/RHC PPS rate and will be equal to the actual acquisition cost (AAC).

Reimbursement will be made only on those drugs manufactured by companies that have a signed rebate agreement with CMS (ARM 37.85.905).

Certified Peer Support Behavioral Health Services

RHC and FQHC providers are eligible to be reimbursed for Certified Peer Support Specialist services, effective July 1, 2019. Please see the Addictive & Mental Disorders Division (AMDD) Provider Manual for Program requirements.

Certified Peer Support Specialist services are reimbursable at a fee-for-service rate utilizing the OPPS fee schedule.

Collaborative Practice Drug Therapy Management (ARM 37.86.901, 37.86.902, and 37.86.905)

Members who have at least one chronic condition needing at least one maintenance medication are eligible for collaborative practice drug therapy

management to be reimbursed the FQHC/RHC PPS rate. The Clinical Pharmacist Practitioner (CPP) must manage a member's drug therapy by providing face-to-face, direct care.

The CPP must be a pharmacist that meets the requirements as outlined in ARM 24.174.526 and must have a collaborative practice agreement with the medical practitioner, as provided in ARM 24.174.524

Visiting Nurses (42 CFR 2416)

Part-time or intermittent nursing care and related medical services other than drugs and biologicals may be provided to a homebound individual (see definition below) by a clinic:

- Only in geographic areas designated by the Secretary of the United States Department of Health and Human Services as having a shortage of home health agencies and services;
- *When services are rendered to a homebound* member *only. A homebound individual is a person who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. For this purpose, place of residence does not include a hospital or long-term care facility.*
- When a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed or compensated by the clinic furnishes services.
- Under a written plan of treatment which is either established and periodically reviewed (at least every 60 days) by a physician or established by a nurse practitioner or physician assistant and periodically reviewed and approved by a supervising physician (at least every 60 days).

Vaccine Reimbursement

The Vaccines for Children (VFC) program makes selected vaccines available at no cost to providers for eligible children 18 years and under.

Vaccines and the administration of vaccines are not covered services in an RHC or FQHC setting and are not separately billable, except for services provided to children enrolled in Healthy Montana Kids (HMK).

Since HMK-enrolled children are not entitled to the VFC program, RHC and FQHC providers may bill Montana Healthcare Programs, for vaccines, using revenue code 636 and the vaccine procedure code.

If a child received a physician or mid-level visit, vaccines will be paid and the administration fees will bundle with the visit fee and pay at zero. If vaccines are administered without a physician or mid-level visit, provider may also bill for the vaccine administration fees using revenue code 771 and vaccines administration procedure codes. An immunization-only fee does not qualify for a visit fee.

Non-Covered Services (ARM 37.85.207)

The following is a list of services not covered by Medicaid. Some of these services may be covered under the EPSDT program for children age 20 and younger based on medical necessity or for individuals covered under the Qualified Medicare Beneficiary (QMB) program. (See the Member Eligibility chapter in the General Information for Providers manual.)

Use OPPS fee schedule to verify coverage for specific services.

- Acupuncture
- Allergen immunotherapy services
- Chiropractic services (under the age of 21)
- Delivery services not provided in a licensed healthcare facility unless as an emergency service
- Dietician/nutritional services
- Dietary supplements
- Exercise programs and programs that are primarily educational, such as:
  - Nutritional programs (under the age of 21)
  - Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
- Homemaker services
- Infertility treatment
- Massage services
- Naturopath services
- Services provided by surgical technicians who are not physicians or midlevel practitioners
- Services considered experimental or investigational
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid member is financially responsible for these services if the member agree in writing before the services are provided. See the Billing Procedures chapter in the General Information for Providers manual.

- Vaccines and the administration of vaccines

Medicaid does not cover services that are not direct member care such as the following:

- Missed or canceled appointments
- Mileage and travel expenses for providers
- Preparation of medical or insurance reports
- Service charges or delinquent payment fees
- Telephone services in home
- Remodeling of home
- Plumbing service
- Car repair and/or modification of automobile

Prior Authorization

For information regarding prior authorization, please refer to the prior authorization link at www.medicaidprovider.mt.gov. You can also refer to the General Provider Manual.

A couple of things to keep in mind:

- Please refer to the most recent OPPS fee schedule to reference the code in question. The fee schedule will indicate if the code needs prior authorization.
- The referring provider should initiate all authorization requests
- When prior authorization is granted, the provider will receive an authorization number that will be required on the claim. The prior authorization number and passport number are two different numbers.
    - For Passport information, please refer to the Passport to Health manual located at www.medicaidprovider.mt.gov.
- Providers must adhere to all prior authorization requirements to avoid claim denials

Medicare Claims

The Department's fiscal agent must have the provider's Medicare number on file to process claims, and providers should include their NPI/API on their Medicare claims.

RHC and FQHC claims automatically cross over from Medicare for dually-eligible members, so providers do not need to send in their crossovers on paper. RHC and FQHC claims that cross over to Medicaid are paid the Medicare coinsurance and deductible less any TPL coverage.

Qualified Medicare Beneficiary (QMB) RHC and FQHC claims that cross over to Medicaid are paid the lesser-of the Medicare coinsurance and deductible or the Medicaid allowable amount.

FQHC claims that cross over to Montana Healthcare Programs are paid the difference between the FQHC Medicaid specific PPS rate and what Medicare paid

When an RHC or FQHC provides services rendered by an LCPC, LAC or CPP, the Medicare EOB is not required as long as the rendering provider is enrolled in Montana Healthcare Programs. Montana Healthcare Programs recognizes that these services are not covered by Medicare, so the denial for the primary carrier EOB is bypassed.

Third Party Liability

When a member is eligible with Montana Healthcare Programs, and another carrier, the other carrier is often referred to as third party liability (TPL). In these cases, the other carrier is typically considered the primary payer and Medicaid will only reimburse the provider when the TPL payment is less than the Medicaid allowable amount.

For more information regarding TPL, please refer to the General Provider Manual.

Healthy Montana Kids (HMK)

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

RHC and FQHC services must be billed either electronically or on a UB-04 claim form.

The information in this chapter does apply to HMK enrolled children when billing for dental, eyeglasses, RHC/FQHC clinic services, or community-based psychiatric rehabilitation services. For more information, contact Blue Cross and Blue Shield at 1-800-447-7828 and visit the HMK website.