FQHC & RHC Program Requirements

Presented by Alyssa Clark

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Agenda

- ✓ Reimbursement Methodology
  - Prospective Payment System (PPS)
  - Fee-for-Service (FFS)
- ✓ Billing Procedures
  - Claim Forms
  - Revenue Codes
  - OPPS Fee Schedule
- ✓ Service Requirements
- ✓ COVID-19 Updates
- ✓ Provider Resources
- ✓ Contact Information

Prospective Payment System (PPS) Rate

- A per-visit rate for each allowable FQHC or RHC service, as defined in ARM 37.86.4401.
- Once a permanent PPS rate is established, it can only be modified under two methodologies:
  - Medicare Economic Index (MEI), and
  - a Change in Scope of Services.

What Defines an FQHC or RHC Service?

- An encounter between a Montana Medicaid member and health professional for the purpose of providing RHC or FQHC services (ARM 37.86.4402).
  - The provider must be on the list of core provider types defined in ARM 37.86.4401.
- Reimbursement is limited to one encounter per day, per eligible member, unless it is necessary for:
  - The member to be seen multiple times a day, due to unrelated diagnoses;
  - or services are rendered by providers of different specialties.

Incidental Services

- PPS payment for visit has services/supplies factored into rate calculation upon establishment.
- Most services and supplies furnished during visit are not reimbursed as stand-alone services.
  - Examples include:
    - Lab services
    - Radiology services
    - Transportation
    - Outreach
    - Drugs and biologicals
    - Fluoride-varnish
    - Vaccine administration (for non-HMK members)

Note: The above is not a complete list of incidental services.

Fee-for-Service (FFS) Rate

- There are some “Non-FQHC/RHC” services that may be reimbursed outside of the PPS rate.
- The department determines which services may be reimbursed at the appropriate FFS rate. The below is the list of current FFS services.
  - Certified Peer Support Services
  - Long-acting reversable contraceptive devices (LARCs)
  - Telehealth originating site fee
  - Promising Pregnancy Care (PPC)
    - Requires facility approval for addition of revenue code 969 on charge file

Claim Forms

- All FQHC and RHC claims are to be submitted on a UB-04 claim form, unless services have been rendered in a hospital setting.
- Services rendered in a hospital setting are reimbursed at the FFS rate by billing on CMS-1500 claim form.
  - Ensure the individual provider's NPI number is entered in the rendering field of the claim form.
  - The FQHC or RHC NPI should be the pay to provider.

Revenue Codes

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 in a covered Part A stay)

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 and LARCs

771 – Vaccine administration fee

779 – Clinical Pharmacist Practitioner

780 – Telehealth originating site

900 – Mental Health Services

910 – Mental Health Peer Support Services

911 – Substance Use Disorder Peer Support Services

942 – Health Education

944 – Substance Use Disorder

969 – Promising Pregnancy Care (Group education session)

Revenue Codes (continued)

- PPS reimbursement is based off the revenue code.
- The revenue code must be billed with an allowable procedure code to be reimbursed.
- Subsequent line items billed with the same revenue code will bundle for one PPS payment.
- Revenue codes 512, 779, 900, and 944 require a change in scope of services request for the department to add to facility's charge file.
- Revenue code 969 may only be added if facility is an approved PPC provider.

Outpatient Prospective Payment System (OPPS) Fee Schedule

- Reimbursable procedure codes can be located on the most recent OPPS fee schedule.
- The fee schedule is accessible through outpatient hospital provider type provider information webpage at www.medicaidprovider.mt.gov/02.
- The reimbursement methodology on the OPPS fee schedule does not apply to FQHC and RHC providers. It is only to be used as a reference for allowable procedure codes.

Service Requirements

The health professional providing the RHC or FQHC service must meet the same requirements that would apply if the health professional were to enroll directly in the Montana Medicaid program in the category of service to be provided (ARM 37.86.4406).

Requirements include (not limited to):

- ✓ Certification
- ✓ Licensing
- ✓ Limitations
- ✓ Record Requirements

COVID-19 Updates

- ✓ Passport requirement lifted on all claims after date of service March 1, 2020.
- ✓ Telephone services are now reimbursable.
  - Revenue code 982 implemented
  - Revenue code 529 pending system changes
- ✓ Distant and originating telehealth providers may now have same tax identification number.
- ✓ Telehealth services may be rendered from member's home.
  - Only distant site reimbursed in this case
- ✓ Department pending CMS guidance for reimbursement of COVID vaccination

Services must still be within the FQHC or RHC's scope of service with Montana Medicaid and provider's scope of licensure

Statute & Regulatory References

- Code of Federal Regulations (CFR)
  - 42 CFR 405.2400 – 42 CFR 405.2472
- Benefit Improvement & Protection Act (BIPA) of 2000
- Montana State Plan
- Administrative Rules of Montana
  - ARM 37.86.4401 – ARM 37.86.4420

Provider Resources

- [Provider Information Webpage]
  - https://medicaidprovider.mt.gov
- General Provider Manual
- FQHC & RHC Provider Manual
- Provider Notices
- Provider Relations
  - 1-800-624-3958
  - Email:MTPRHelpdesk@conduent.com

Contact Information

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Questions