FQHC/RHC PPS PA Medicaid Billing Guide*

(Effective January 1, 2017)

Overview

Effective January 1, 2016, Gateway Health (Gateway) will pay all Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) rate(s) that are not less than the Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by the Department of Human Services (DHS). ***This guide is intended as a reference for **Medical Service Encounters only (Behavioral Health services must be billed to the BH-MCO in your county)** for Gateway Pennsylvania Medicaid members. Providers should refer to Gateway's dental benefit provider, United Concordia Dental (UCD), for instructions on submitting Dental Service Encounters.

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. i. Eligible Providers include:

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

Claim Submission

- FQHCs and RHCs may submit claims for medical encounters provided to Gateway members on paper CMS 1500 forms or electronic
  837P claim forms. (Refer to the Gateway Medicaid Policy and Procedure Manual located under Providers at www.GatewayHealthPlan.com for information on Timely Filing Guidelines and Electronic Claims Submission.)
- **The encounter code T1015 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.**

- **Refer to the attached Maternity – Prenatal and Postpartum Care Guide for Maternity/Obstetrical billing instructions.**
- 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, complete diagnosis codes regardless of expected payment.

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 References

MLN Matter Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) link below pages 3-4 for the (5) FQHC Specific Payment G-HCPCS Codes: https://www.cms.gov/Outreach-andEducation/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8743.pdf

MLN Matter Required Billing Updates for Rural Health Clinics link below pages 9-11 RHC Medical Services, Approved Preventive Health Services and Medical Health Services (68) 9 series & G-HCPCS Codes: https://www.cmGs.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9269.pdf