Gateway Health

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FQHC/RHC PPS Billing Guide*

(Effective January 1, 2016)

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

[1] FQHC Webinar Info 120115

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.

Maternity – Prenatal and Postpartum Care

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Gateway Health Plan® wants to help you maximize your bonus dollars and improve HEDIS® rates. This tip sheet details the key aspects of Prenatal and Postpartum Care along with specific bonus criteria.

What is the Metric?

Information in this sheet applies to Medicaid female patients who are continuously enrolled and deliver a live birth. The 3 areas of focus are:

- **Timeliness of Prenatal Care:** One Prenatal intake visit in the first trimester or within 42 days of enrollment with Gateway Health Plan
- **Frequency of Prenatal Care:** Regular visits during the pregnancy. Frequency may vary due to risk factors
- **Postpartum Care:** One Postpartum visit within **21-56** days after the delivery date.

Exclusions: Patients who miscarry or leave Gateway Health before the 56th day after a live birth.

Suggested Maternity Codes

This is not an all-inclusive list. Refer to the Provider manual and coding tip sheet for further details.

Description	ICD-10-CM	CPT Code	CPT II
Prenatal Codes*	Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93	99201-99205, 99211-99215	0500F (Intake Visit) 0502F (Subsequent Visits)
Postpartum Codes	Z39.2	Use any current, valid postpartum code	0503F
***A code from Z3A will be needed each visit to indicate weeks of gestation**			
Include dates of service on HCFA 1500 form and identify with valid E & M codes with U9 pricing modifier in the first position on the claim form			

How Can Providers Improve HEDIS Scores

- Provide an appointment in the first trimester whenever possible.
- Return the OBNAF form to Gateway in a timely fashion so our Maternity Team can make appointment reminder calls and assist with transportation resources.
- Encourage regular visits during pregnancy.
- Provide patients with directions on how to access after hour care if available
- Reinforce the importance of a postpartum visit **21-56** after delivery
- Avoid global billing
- Remind patients that they qualify for an incentive if they have a first trimester visit and keep all appointments during their pregnancy
- Remember to take advantage of the generous provider incentives (see back page for details)

State of PA Care Requirements for Medicaid Recipients

Please complete in the **first 2 prenatal visits**:

- Prenatal depression screening, counseling and referral for depression if needed
- Notation of standard depression scale name
- Tobacco, Alcohol, Illicit Drug use screening and counseling
- Environmental Tobacco exposure screening and counseling
- Intimate Partner Violence screening and counseling
- Medication Review

Please complete this during the Postpartum period (**21-56 days after delivery**)

- Postpartum Depression screening, counseling and referral if needed
- Notation of standard depression scale name

Two provider incentives are now available! (paid in addition to fee for service)

Your practice can receive $200 for completing a prenatal visit in the first trimester.

1. Submit the following *on the same claim*: procedure codes 99429-HD and T1001-U9 within 180 days of intake visit
2. Fax a complete 2015 OBNAF form within 30 days of the intake visit.
3. Fax to 412-255-5639 or 1-888-225-2360.

Late, incomplete or outdated OBNAFS will jeopardize incentive payment

As of January 1, 2015, your practice can receive $75 for completing a postpartum visit **21 to 56** days after the delivery date.

1. Use current, valid postpartum care code
2. Postpartum Incentives are paid once per quarter

Resources

The Maternity Team is available for questions at 800-642-3550 #2

To navigate to the Provider Manual or The Coding Tip Sheet go to:

www.gatewayhealthplan.com > Providers > Provider Manual > Medical Assistance Provider Manual > OB/GYN Services

www.gatewayhealthplan.com > Providers > Gateway to Practitioner Excellence® > The Coding Tip Sheet