Overview of Methodology

Managed care organizations (MCO’s) will concurrently pay contracted rate, wrap payment, and any fee for service (FFS) payments excluded from the PPS (Prospective Payment System) rate.

1. Services included in PPS rate:
   • General Medical
   • Health steps
   • Behavioral Health
   • Case management
   • Vision

2. The new reimbursement arrangements will become effective:
   STAR/STAR Kids: September 1st, 2017
   CHIP: March 24th, 2018 or April 1st, 2018

3. The CMS-1500 will be the standardized across plans and products. Claims billed on a UB-04 will be denied.
Billing Guidelines

FQHC submits claim to MCO with the following minimum requirements for STAR/STAR Kids and CHIP

1. Billing provider taxonomy 261QF0400X.
2. T1015 to flag wrap payment. Claims without this code will not be eligible for wrap payment. The PPS rate will be entered as the line charge for T1015.
3. Appropriate procedure codes, corresponding modifiers, and diagnosis codes. Multiple procedure codes can be billed on the same claim form for a single DOS. However a separate claim form is required for each FQHC service category.
4. Claims received without the subsequent CPT/HCPCS codes will be denied.
5. The following CPT/HCPCS are examples of codes that are paid in addition to the PPS rate:

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>OB services</th>
<th>After Hours</th>
<th>Family Planning</th>
<th>Family Planning</th>
<th>Family Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0004</td>
<td>59409</td>
<td>99050</td>
<td>J7297</td>
<td>99201</td>
<td>99211</td>
</tr>
<tr>
<td>H0005</td>
<td>59430</td>
<td>99051</td>
<td>J7298</td>
<td>99202</td>
<td>99212</td>
</tr>
<tr>
<td></td>
<td>59612</td>
<td>99053</td>
<td>J7300</td>
<td>99203</td>
<td>99213</td>
</tr>
<tr>
<td></td>
<td>59514</td>
<td>99056</td>
<td>J7301</td>
<td>99204</td>
<td>99214</td>
</tr>
<tr>
<td></td>
<td>59620</td>
<td>99058</td>
<td>J7307</td>
<td>99205</td>
<td>99215</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>99060</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

**General Medical Office Visit**
Encounter rate triggered by T1015 code and allowable CPT/HCPCS code

1. Allowable CPT/HCPCS
   - 99202-99205: Acute New Patient
   - 99211-99215: Acute Established Patient
   - 99241-99245: Consultation for New or Established Patient
   - 99304-99310: Nursing Facility Visit
   - 99318: Annual Nursing Home Assessment
   - 99324-99328: Assisted Living Visit for New Patient
   - 99334-99337: Assisted Living Visit for Established Patient
   - 99341-99346: Home Visit for New Patient
   - 99347-99350: Home Visit for Established Patient
   - 99385-99387: Preventive Medicine for New Patient
   - 99395-99397: Preventive Medicine for Established Patient
   - 10003-69999 (excluding 36400-36425)

2. Eligible providers
   - Physician
   - Physician’s Assistant
   - Nurse Practitioner
   - Certified Nurse Midwife
   - Professional

3. Modifiers: Prefer to keep current TMHP modifier structure in place
Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

**THSteps Services**

Encounter rate triggered by T1015 code and allowable CPT/HCPCS code

1. Allowable CPT/HCPCS codes
   - 99381-99385: Preventive Visit New Patient
   - 99391-99395: Preventive Visit Established Patient
   - 99429: THSteps Oral Evaluation and Fluoride Varnish
   - THSteps Vaccine Admin: 90460-90461, 90471-90474, 96160-96161, 86580

2. Eligible providers
   - Physician
   - Physician’s Assistant
   - Nurse Practitioner
   - Certified Nurse Midwife

3. Modifiers
   - EP for 99381-99385* and 99391-99395* to indicate THSteps Medical Checkup
     (*for clients who are 18 through 20 years of age)
   - EP for 99429 plus U5 modifier to indicate THSteps Oral Exam
   - Same structure as General Medical Office Visit to identify provider type
Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

**Case Management Services**

Encounter rate triggered by T1015 code and allowable CPT/HCPCS code

1. Allowable CPT/HCPCS codes
   - G9012

2. Eligible providers
   - Case Managers

3. Modifiers
   - U5 and U2: Comprehensive visit
   - U5 and TS: Follow up face-to-face
   - TS: Follow up telephone

* Federally Qualified Health Center (FQHC) facilities that provide Case Management for Children and Pregnant Women services will use their FQHC number and should not apply for an additional provider number for Case Management for Children and Pregnant Women.
Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

**Family Planning Services (paid outside PPS encounter rate)**
(Centers currently reimbursed at PPS encounter rate) Allowable CPT/HCPCS code with FP modifier

1. Allowable CPT/HCPCS codes
   - OB Delivery Codes: 59409, 59612, 59514, 59620
   - 59430: Post-Partum Visit Code
   - 99201-99205: Acute New Patient
   - 99211-99215: Acute Established Patient

2. J codes paid at fee for service rate in addition to PPS rate

**IUD J codes**
- J7297: IUD (Liletta)
- J7298: IUD (Mirena)
- J7300: IUD (ParaGard)
- J7301: IUD (Skyla)

Note: IUD Insertions/Removals must be reported with the following CPT codes to get PPS Encounter Rate Reimbursement:
- 58300: IUD Insertion
- 58301: IUD Removal

**Contraceptive Implant J-Code**
- J7307: Contraceptive Implant System (including implant and supplies)

Note: Contraceptive implant insertions/removals must be reported with the following CPT codes to get PPS rate:
- 11981: Insertion of Contraceptive Implant
- 11983: Removal and Reinsertion of Contraceptive Implant
- 11976, 11982: Removal of Contraceptive Implant
Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

**Family Planning Services (paid outside PPS encounter rate)**

3. Eligible providers
   - Physician
   - Physician’s Assistant
   - Nurse Practitioner
   - Certified Nurse Midwife

4. Modifier
   - FP
   - J1050 with U1 modifier also
   - All other J codes with U8 modifier also
Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

**Behavioral Health Services**

Encounter rate triggered by T1015 code and allowable CPT/HCPCS code

1. Allowable CPT/HCPCS codes
   - 90791-90792: Psychiatric Evaluation
   - 90832, 90834, 90837, 90839: Individual Psychotherapy
   - 90833 (30 min), 90836 (45 min) and 90838 (60 min) are add-on psychotherapy codes based on the length of time of the psychotherapy provided. These do not trigger an encounter rate.
   - 90846: Family Psychotherapy (without Patient)
   - 90847: Family Psychotherapy (with Patient)
   - 90853: Group Psychotherapy
   - 90899: Unlisted Psychiatric Service or Procedure
   - 96101-96118: Psychological Assessment and Intervention
   - 96150-96155: Behavioral Health Assessment and Intervention
   - 99201-99205: E&M Office Visit with BH Diagnosis for New Patient
   - 99211-99215: E&M Office Visit with BH Diagnosis for Established Patient
   - 99408: Alcohol and/or drug services, brief intervention (15+ minutes) contains a note stating FQHCs should submit claims using SBIRT procedure codes for informational purposes only.
   - H0049: Alcohol and SA screening (required if screening results are negative)
   - H0050: Alcohol and SA Brief Intervention (Ambulatory outpatient detoxification)
Codes currently being paid to FQHCs at PPS encounter rate and related codes paid at fee for service

Behavioral Health Services

2. Substance abuse therapy codes are paid fee for service only
   • H0004: Individual Substance Abuse Therapy. H0004 reimburses $14.50 for 15 min of services
   • H0005: Group Substance Abuse Therapy. H0005 reimburses $18 for 60 minutes of service.

3. Eligible providers
   • Physician (E&M only)
   • Physician’s Assistant (E&M only)
   • Nurse Practitioner (E&M only)
   • Certified Nurse Midwife (E&M only)
   • Psychiatrist
   • Clinical Psychologist
   • Psychiatric Nurse Practitioners
   • Licensed Clinical Social Workers
   • Licensed Professional Counselors
   • Licensed Marriage and Family Therapists
   • Alcohol and Drug Abuse Counselors (Substance Abuse Therapy only)

4. Modifiers
   • Prefer to keep current TMHP modifier structure in place
- Box 24 B: Use location 50 to identify place of service
- Box 24 I: Rendering provider taxonomy
- Box 24 J: Leave rendering provider area blank
- Box 28: Reflects the total cost of all services provided during the encounter, not just the PPS rate
- Box 30: Reflect the PPS/encounter reimbursement rate
- Box 32 a: Facility NPI
- Box 32 b: Facility taxonomy
- Box 33: Physical billing address. A PO Box is not allowed per HIPPA guidelines
- Box 33 a: Billing NPI
- Box 33 b: Billing Taxonomy (261QF0400X)
### Claim Example: LARC Example

**FQHC ABC PPS RATE - $153.12**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Billed Amount</th>
<th>Paid Amount</th>
<th>Notes</th>
<th>Explanation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
<td>TH</td>
<td>AM</td>
<td>$153.12</td>
<td>$70.44</td>
<td>Contractual</td>
<td>EX2B – Negotiated Flat Payment</td>
</tr>
<tr>
<td>99213</td>
<td>TH</td>
<td>AM</td>
<td>$50.00</td>
<td>$82.69</td>
<td>Wrap</td>
<td>EXD1 – Wrap Payment</td>
</tr>
<tr>
<td>58300</td>
<td></td>
<td></td>
<td>$100.00</td>
<td>$0.00</td>
<td>Global</td>
<td>EX04 – Included In Global Rate</td>
</tr>
<tr>
<td>J7298</td>
<td></td>
<td></td>
<td>$120.00</td>
<td>$85.00</td>
<td>Not part of wrap</td>
<td>EX01 – Paid per Contractual Agreement</td>
</tr>
</tbody>
</table>
**Claim Example: THSteps**

**FQHC ABC PPS RATE - $153.12**

**HEALTH INSURANCE CLAIM FORM**

1. **MEDICARE**
2. **TRICARE**
3. **CHAMPVA**
4. **OTHER**

**Claimant Information**

- **INSURED'S ID. NUMBER**
- **NAME**
- **DATE OF BIRTH**
- **SEX**
- **INSURED'S DATE OF BIRTH**
- **IDENTIFIED BY**

**Provider Information**

- **FQHC ABC**
- **PPS RATE**
- **$153.12**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Billed Amount</th>
<th>Paid Amount</th>
<th>Notes</th>
<th>Explanation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
<td>EP</td>
<td>SA</td>
<td>$153.12</td>
<td>$70.44</td>
<td>Contractual</td>
<td>EX2B – Negotiated Flat Payment</td>
</tr>
<tr>
<td>99384</td>
<td>EP</td>
<td>SA</td>
<td>$100.00</td>
<td>$82.69</td>
<td>Wrap</td>
<td>EXD1 – Wrap Payment</td>
</tr>
<tr>
<td>90471</td>
<td></td>
<td></td>
<td>$35.00</td>
<td>$0.00</td>
<td>Global</td>
<td>EX04 – Included In Global Rate</td>
</tr>
<tr>
<td>90634</td>
<td></td>
<td></td>
<td>$0.01</td>
<td>$0.00</td>
<td>TFVC</td>
<td>EX71 – Drug Covered Through TVFC Program</td>
</tr>
</tbody>
</table>

**PPS Rate**

- **09/02/2017**
- **Signature on file**
- **887654321**
- **9123456789**
- **261QFD400X**
- **Clear Form**

**NUCC Instruction Manual available at www.nucc.org**

**PLEASE PRINT OR TYPE**

**APPROVED CM8-06-00**

**10-25-12**

**Physician or Supplier Information**

- **Provider ID**
- **Address**
- **Signature**
- **Provider Name**
- **Invoice Number**

**RECEIVED DATE**

**SIGNATURE ON FILE**

**NUCC Carrier Information**

- **Address**
- **Phone Number**
- **Fax Number**
- **Signature**

**NUCC Claim Form**

**APPROVED CM8-06-00**

**10-25-12**
<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Billed Amount</th>
<th>Paid Amount</th>
<th>Notes</th>
<th>Explanation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
<td>AM</td>
<td></td>
<td>$153.12</td>
<td>$70.44</td>
<td>Contractual</td>
<td>EX2B – Negotiated Flat Payment</td>
</tr>
<tr>
<td>90791</td>
<td>AM</td>
<td></td>
<td>$100.00</td>
<td>$82.69</td>
<td>Wrap</td>
<td>EXD1 – Wrap Payment</td>
</tr>
<tr>
<td>Code</td>
<td>Modifier 1</td>
<td>Modifier 2</td>
<td>Billed Amount</td>
<td>Paid Amount</td>
<td>Notes</td>
<td>Explanation Code</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>------------</td>
<td>---------------</td>
<td>-------------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>97170</td>
<td></td>
<td></td>
<td>$30.00</td>
<td>$30.00</td>
<td>Value Add</td>
<td>EXVN – Value Add Benefit</td>
</tr>
</tbody>
</table>
Encounter with COB

Any TPL (Third Party Liability) will be applied first to the wrap payment and then to the contracted rate. For example:

PPS rate: $200
FFS: $75
TPL: $100

$200 PPS - $75 FFS/flat = 4125 wrap
$125 wrap - $100 TPL = $25 wrap

Or alternatively:

$200 PPS - $100 TPP = $100 balance
$100 - $75 FFS/flat = $25 wrap

If the TPL is more than the wrap but less than the PPS, it can then also be applied to the MCO payment:

$200 PPS - $75 FFS/flat = $125 wrap
$125 wrap - $150 TPL = $0 wrap - $25 TPL
$75 FFS/flat - $25 TPL = $50 FFS/flat

Or alternatively:

$200 PPS - $150 TPP = $50 balance
$50 - $50 FFS/flat = $0 balance (+ $0 wrap)