From Encounter to Reimbursement: A How to Guide for FQHC/RHC Billing

2025 IHCP Works Annual Seminar

Agenda

- Acronyms
- Test Your Knowledge
- Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) – What are they?
- Billing Encounters
- Crossover Claims & Carved-Out Services
- Dental Billing
- Telehealth Services
- Wrap Payments & Remittance Advice (RA)
- Resources
- Questions

Acronyms

Federally Qualified Health Center (FQHC)
Fee-for-Service (FFS)
Healthcare Common Procedure Coding System (HCPCS)
Indiana Health Coverage Programs (IHCP)
Long-Acting Reversible Contraception (LARC)
Managed Care Entity (MCE)
National Provider Identification (NPI)
Notice of Pregnancy (NOP)
Office of Medicaid Policy and Planning (OMPP)
Place of Service (POS)
Prospective Payment System (PPS)
Rural Health Clinic (RHC)
Remittance Advice (RA)

Test Your Knowledge

There is no difference between an FQHC or RHC?

True or False

Billing FQHC/RHC claims require a special code only?

True or False

Billing dental claims for FQHC/RHCs do not require additional coding?

True or False

Wrap payments are reported on the remittance advice?

True or False

FQHC/RHC – What are they?

What is a FQHC?

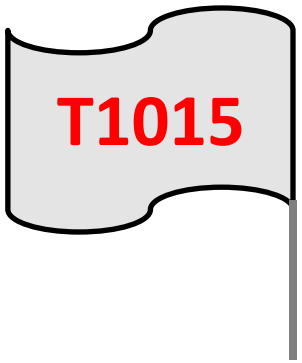
- FQHCs provide access to primary care in areas where primary care resources are constrained or experience shortage of healthcare providers.
- FQHCs include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Centers, and Public Housing Primary Care Centers.
- FQHCs are required to be community-centered and either not-for-profit or a public organization that emphasizes coordination of care.

What is a RHC?

- Care centers that provide services that are typically furnished in an outpatient clinic setting.
- The RHC program is intended to increase access to primary care services for patients in rural communities.
- RHCs must be located in non-urbanized areas, as defined by the U.S. Census Bureau.
- RHCs can be:
  Hospital-Based (HB): Owned and operated as an essential part of a hospital, nursing home or home health agency.
  Freestanding: Free-standing clinics are owned by a provider or provider entity.

Billing Encounters

FQHC/RHC Medical Billing Process



- FQHCs and RHCs **must** include the **T1015** code on all Medical and Behavioral Health claims.

- Multiple encounter claims from an FQHC for a member on the same date of service that do not include a different primary diagnosis code are denied for EOB 5000 or 5001 – *This is a duplicate of another claim*.

- Same day services that are of a different nature and scope **must** be billed on a **separate** claim with the **T1015** code and a different primary diagnosis code.
  - *An example of same day services would be a primary care visit and a behavioral health visit where the primary diagnosis for each claim would match the reason for the visit.*
- To receive the wrap payment, you will need to make sure that the **T1015** is on each claim submitted.

- As a reminder, FQHCs/RHCs should be billing NOP (G9997 TH) claims with the office visit and a **T1015** as of January 1, 2025. If a claim for NOP is submitted without a **T1015** and a valid encounter, the claim will deny.

Crossover & Carve-Out Billing

Crossover, Secondary & Carved-out Services Claims

- Crossover claims and claims for carved-out services do not require the **T1015**.

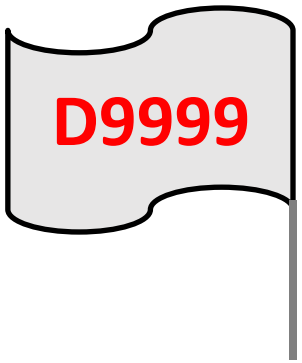
- Carved-out services (COVID-19 Vaccine Administration and LARC products) should be submitted without the **T1015** and **must** include the POS **code 71.**

- Secondary claims require the **T1015** because they qualify for wrap payments. If secondary claims are submitted in error **without** the **T1015** code**,** the claim will deny and should be resubmitted **with** the **T1015** code.

- **All** claims must be submitted under the NPI associated with the FQHC/RHC enrollment for the service location and the appropriate taxonomy code.

Dental Billing

Dental Wrap Automation Process



- Like medical and behavioral health claims, dental claims require an added code to trigger the wrap payment.
- **All** dental claims (managed care and FFS) must be billed with the code **D9999** to make sure that all eligible encounters receive the wrap payment.
- All claims must be submitted using the NPI associated with the FQHC/RHC enrollment and the appropriate taxonomy code for dental services.

Dental Update - Global Encounter Review

- Global dental encounters (services that require more than one visit on different dates of service to complete the service) will still be reviewed outside of the wrap automation.

- Myers and Stauffer will continue requesting additional information for global dental encounters, via email, as part of the dental year-end settlement process.

- Responding to these requests from Myers and Stauffer will ensure that your year-end dental settlements are accurate and that you will receive adequate reimbursement for those services.

Telehealth Services

FQHC/RHC Telehealth Services

- **All** telehealth services provided by a FQHC/RHC must be on **both** the telehealth code set and the FQHC/RHC valid encounter code set to receive reimbursement when they are serving as either the distant site or the originating site.

- When the FQHC/RHC is the distant site (the location of the provider rendering services), the service must meet the above. The claim must include the T1015 with a place of service code 11, 12, 31, 32, 50, or 72; the encounter code must be billed with a modifier 93 or 95 and POS 02 or 10.

- When the FQHC/RHC is the originating site (the location where the patient is physically located), the claim must include a T1015 with a POS code 11, 31, 32, 50, or 72; the HCPCS code Q3014 will be billed with the POS code 02 and modifier 95. Separate reimbursement for merely serving as the originating site is not available to FQHCs/RHCs when the presence of a medical professional is not medically necessary. Without the presence of a valid encounter and a medically necessary professional, this claim does not meet the requirements to qualify for PPS logic.

**Pursuant to the *Code of Federal Regulations 42 CFR 405.2463*, an encounter is defined by the Centers for Medicare & Medicaid Services (CMS) as a face-to-face meeting between an eligible provider and a Medicaid member during which a medically necessary service is performed. Consistent with federal regulations, for an FQHC or RHC to receive reimbursement for services, including those for telemedicine, the criteria of a valid encounter must be met.

Wrap Payments & Remittance Advice

Wrap Report

- RA Automatic Posting
  - RA is configured to automatically post when downloaded in the 835 file.
  - Individual software may need to be modified to accept the expenditure portion of the RA as a payment.

- Modify Wrap Report
  - Layout of the current RA is divided by payment type (payments, crossover payments, expenditures, adjustments, etc.).
  - FFS wrap payments are on the payment section because Medicaid pays the whole claim.
  - The wrap section of the RA is an expenditure because the MCEs pay the claim.

Remittance Advice for Wrap Payments

REPORT: CRA-WPPY-R
RA#: XXXXXXX
PAYER: TXIX

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
WRAP AROUND SERVICES EXPENDITURES

DATE: DD/MM/YYYY
PAGE: XXX

PROVIDER NAME
PROVIDER ADDRESS
CITY, STATE ZIP-ZIP FOUR

PAYEE ID XXXXXXXXXXA MCD
NPI XXXXXXXXXX
PAYMENT NUMBER XXXXXXXXX
PAYMENT DATE MM/DD/YYYY

MCE ID

Sum of All Payers

MEMBER NO.	--ICN--	PATIENT NO.	SERVICE DATES FROM	SERVICE DATES TO	BILLED AMT	WRAP AROUND AMOUNT	TRANSACTION NUMBER
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	18,341.49	111.92	728467
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	4,353.72	102.19	728466
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	4,353.72	111.92	728465
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	4,662.72	102.19	728464
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	4,353.72	102.19	728463
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	74,574.76	408.74	728462
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	3,623.77	102.19	728461
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	12,711.37	165.44	728460
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	13,880.58	111.92	728459
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	12,880.77	165.44	728458
XXXXXXXXXX	99 7019XXXXXXXXX	XXXXXXXXXXXX	MMDDYY	MMDDYY	55,872.65	126.52	728457
		TOTAL WRAP AROUND SERVICES PAID:			209,609.27	1,610.66	

Remittance Advice for Coinsurance

|-M E D I C A R E A M T S-|

--ICN-- PATIENT NO. SERVICE DATES COPAY AMT ALLOWED AMT PSYCH CO-INS BILLED COPAY AMT OUTPAT DED PAID AMT
MRN FROM TO PAID AMT DEDUCT CO-INS OTH INS AMT SPENDDOWN CO-INS CB

MEMBER NAME: [redacted] MEMBER NO.: [redacted]

2024[redacted] [redacted] 021224 021224 0.00 0.00 0.00 [redacted] 0.00 0.00 24.96

[redacted] 73.48 0.00 0.00 0.00 0.00 0.00

MODIFIERS SER DT FROM TO RENDERING PROV ALLW UNITS PA NUMBER
REV CD PROC CD COPAY AMT SPENDDOWN AMT BILLED AMT ALLOWED AMT PAID AMT

0 T1015 021224 021224 MCD [redacted] 0.00
0.00 0.00 [redacted] 0.00 0.00
0 99214 021224 021224 MCD [redacted] 1.00
0.00 0.00 175.00 24.96 24.96

EOBS 001 0593 9806 9916
002 9806 9920 9947
ARCS 001 A1 [redacted]
002 45 150.04
REMARKS 001 M28

Remittance Advice for FFS PPS Payment

--ICN-- PATIENT NUMBER MRN SERVICE DATES BILLED AMT OTH INS AMT COPAY AMT PAID AMT
FROM TO ALLOWED AMT SPENDDOWN AMT CO-INS CB OUTPAT DED
MEMBER NAME: [redacted] MEMBER NO.: [redacted]

2024[redacted] 012524 012524 700.00 0.00 0.00 350.00

350.00 0.00 0.00 0.00

SERVICE DATES ALLW UNITS RENDERING PROVIDER PA NUMBER
PROC CD MODIFIERS FROM TO COPAY AMT BILLED AMT ALLOWED AMT PAID AMT
T1015 U2 012524 012524 1.00 MCD [redacted]

0.00 350.00 350.00 350.00

1REPORT: CRA-HCPD-R INDIANA CORE MMIS DATE: 03/15/2024
RA#: [redacted] INDIANA TITLE XIX PAGE: [redacted]
PAYER: TXIX PROVIDER REMITTANCE ADVICE
PROFESSIONAL SERVICES CLAIMS PAID

[redacted]

PAYEE ID [redacted] MCD
NPI [redacted]
PAYMENT NUMBER [redacted]
PAYMENT DATE 03/20/2024

Reporting Enhancements

- Wrap reports are now available on the Indiana Medicaid for Providers Healthcare Portal under the claims tab.
- Providers can first request a report using a 30-day span/31-day date of service span per request.
- Providers can submit as many requests as they want (i.e. a report for dates of service for each month for a year = 12 requests).
- The requested report(s) will be available the next day to download.
- The report will be in .csv format so providers can convert to Excel.
- OMPP is working on a project to change the date span from ‘dates for service’ to ‘paid dates’.

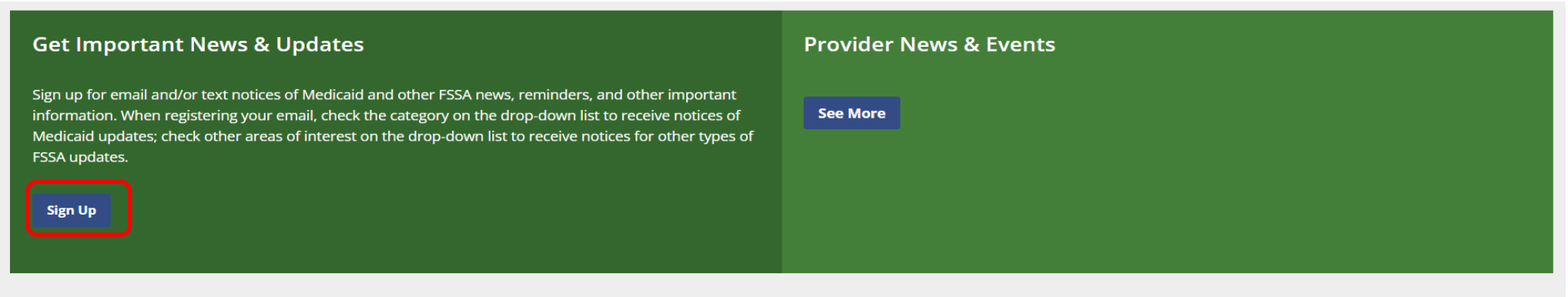
Resources

Provider Resources

- Provider Relations Consultants – Provider first source of contact with Gainwell Provider Relations Team for fee-for-service claim concerns.
- Quick Reference Guide – A comprehensive resource with Gainwell contact, Managed Care Entities and Acentra (prior authorization Vendor).
- Provider Reference Materials – Bulletins and reference modules, Current News, Forms, IHCP Provider Locator, Code Sets and much more.
- Provider Education - Provider Education Opportunities, 2025 IHCP Works seminar, Archived Workshop Presentations, IHCP Live, IHCP Quick Hits, IHCP Provider Healthcare Portal Training and more.
- Myers and Stauffer – FQHC Indiana Medicaid Cost Report, FQHC/RHC Annual Encounter Code Listings and more.

Sign Up for Updates!

- Register for updates on the Indiana Medicaid Provider Website



How Can We Help You?

****Be sure to utilize the Gainwell or MCE provider relations team first****

- OMPPFQHC-RHCReimbursement@fssa.in.gov
  FQHC/RHC claim questions or issues can be sent to this mailbox for assistance.

- OMPPProviderRelations@fssa.IN.gov
  For individual provider concerns requiring assistance from the State.

- IHCPListens@fssa.in.gov
  Feedback on IHCP presentations.
  Ideas for future presentations/workshops.
  Questions to be answered in future publications

Questions?

Please scan the QR code and complete the session evaluation!