Federally Qualified Health Center Payment Process Quick Reference Guide

Wrap Payment Process and Methodology

Superior HealthPlan will initiate claims system changes for Federally Qualified Health Center (FQHC) claims with dates of service of September 1, 2017 and later. The changes will align with the Texas Health and Human Services (HHS) contract amendment and direction related to FQHC payments, which include required claims elements for reimbursement of FQHC claims at Fee-For-Service + Wrap Service = Prospective Payment System (PPS) Encounter Rate, and encounter submission to HHS for Superior reimbursement of wrap service payment amounts.

To maintain consistent claims processes for FQHCs, Superior will require both Medicaid and CHIP claims to be billed using the requirements listed below.

General Claims Requirements

Provider must bill claims:

- On a CMS1500 claim form.
- With the rendering/servicing provider NPI/taxonomy in box 24 I/J, if required.
- With the billing provider's NPI in box 33a and billing provider's taxonomy in box 33b.
- With the location where services were provided in box 32.
    - With the NPI of the facility where the services were provided in box 32a.
    - With the taxonomy of the facility where the services were provided in box 32b (Please note: boxes 32a and 32b can differ from NPI and taxonomy in 33a and 33b).
- With the appropriate location code where the services were provided, for services provided outside the FQHC site (i.e. location 21 for inpatient hospital). *Please note: Services performed outside FQHC will be paid at the Medicaid Fee-For-Service reimbursement rate.*

Claims Requirements to Trigger PPS Rate (Medicaid Fee-For-Service + Wrap Service)

Provider must bill claims:

- On a CMS1500 claim form.
- Using **Location Code 50.**
- With the billing provider's NPI in box 33a and billing provider's **taxonomy (261QF0400X)** in box 33b.
    - 33b must be a FQHC taxonomy code to trigger PPS encounter rate payment and for Superior encounter submission.
- With a procedure code **T1015** and all applicable modifiers (AH, AJ, AM, SA, TD, TE, or U7) in order to receive an encounter payment, and a PPS rate on first service line of the claim form, in addition to appropriate procedure codes for services provided (including all applicable modifiers and the provider's usual customary charge). *Please note: Providers will not be reimbursed an encounter rate without a face-to-face encounter procedure code billed in addition to the T1015 procedure code*.
- With a modifier TH for antepartum or postpartum care.
- With the appropriate family planning diagnosis code for family planning services.
- Rendering Provider NPI/taxonomy required for THSteps and Family Planning visits.
- For each face-to-face encounter, along with the procedure code for services provided on a separate claim (example: THStep visit, BH visit and General Medical visit would be billed on separate claims).

Claims Payment

- Superior will adjudicate procedure codes submitted at Medicaid Fee-For-Service. Simultaneous wrap service (up to PPS encounter rate) will be calculated and paid for the T1015 procedure code and include reimbursement at the full FQHC PPS encounter rate.
- The total claim payment will not exceed the provider's PPS encounter rate, unless codes for after-hours services or Long-Acting Reversible Contraception (LARC) procedure codes (J7297, J7298, J7300, J7301, and J7307) are billed. *Please note: After-hours care and LARC services will be paid in addition to the provider's PPS encounters rate.*
- FQHCs with questions about denied claims or concerns about payment accuracy should call Superior's Provider Services department at 1-877-391-5921. Provider Services will be able to explain the reason for the claim denial or payment amount and determine appropriate next steps.

Superior-Family Planning
(T1015 with F2F)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. Z3009 B. Z01419 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	08	2018	02	08	2018	50		T1015	FP AM	AB	151 03	1		NPI
2	02	08	2018	02	08	2018	50		99214	FP AM	AB	200 00	1		NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789 ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ 351 03

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Random TX Health Center
100 Main St.
Random, TX. 77777

a. 1111111111 b. 261QF0400X

33. BILLING PROVIDER INFO & PH # ( )

Random TX Health Center
100 Main St.
Random, TX. 77777

a. 1111111111 b. 261QF0400X

Superior-LARC+ WRAP with modifier U8 (340B Program)
(T1015 w/ F2F, LARC)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) / (Medicaid#) / (ID#/DoD#) / (Member ID#) / (ID#) / (ID#) / (ID#)	123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. RESERVED FOR NUCC USE
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. Z30430 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 02 2018 01 02 2018	50		T1015	AM	A	150 00	1		NPI	
2 01 02 2018 01 02 2018	50		99213	AM	A	100 00	1		NPI	
3 01 02 2018 01 02 2018	50		J7301	U8	A	400 00	1		NPI	
4 01 02 2018 01 02 2018	50		58300		A	50 00	1		NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
123456789					

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	Random TX Health Center 100 Main St. Random, TX. 77777	Random TX Health Center 100 Main St. Random, TX. 77777
	a. 1111111111 b. 261QF0400X	a. 1111111111 b. 261QF0400X

Superior- Sick Visit
(T1015 with F2F)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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PHYSICIAN OR SUPPLIER INFORMATION

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. R197 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	12	2018	01	12	2018	50		T1015	AM	A	156	03	1		NPI	
2	01	12	2018	01	12	2018	50		99213	AM	A	150	00	1		NPI	
3																NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Random TX Health Center
100 Main St.
Random, TX. 77777

a. 1111111111 b. 261QF0400X

33. BILLING PROVIDER INFO & PH # ( )

Random TX Health Center
100 Main St.
Random, TX. 77777

a. 1111111111 b. 261QF0400X

Superior- THSTEPS with vaccines
(T1015 with F2F,immunization, and admin)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. Z30014 B. Z23 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	28	2017	09	28	2017	50	N	T1015	SA EP	BA	117 07	1		NPI	
2	09	28	2017	09	28	2017	50	N	99391	SA EP 25	BA	100 00	1		NPI	
3	09	28	2017	09	28	2017	50	N	90471		A	50 00	1		NPI	
4	111111111111 ML 1															
	09	28	2017	09	28	2017	50	N	90715		A	100 00	1		NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 367 07

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Random TX Health Center
100 Main St.
Random, TX. 77777

a. 1111111111 b. 261QF0400X

33. BILLING PROVIDER INFO & PH # ( )

Random TX Health Center
100 Main St.
Random, TX. 77777

a. 1111111111 b. 261QF0400X