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 I MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN (ID#) 1a. INSURED'S I.D. NUMBER (For Program in Item 1) BLK LUNG (ID#) 123456789 (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) 7 (ID#) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SEX 5. PATIENT'S ADDRESS (No., Street) . INSURED'S ADDRESS (No., Street) Child Self Spouse CITY STATE 8. RESERVED FOR NUCC USE CITY STATE INFORMATION ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) AND INSURED a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) INSURED'S DATE OF BIRTH FΓ b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? b. OTHER CLAIM ID (Designated by NUCC) PLACE (State YES ENT c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? . INSURANCE PLAN NAME OR PROGRAM NAME NO YES d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 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 ot 3. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. to process this claim. I also request payment of government benefits either to myself or to the party who accepts MM DD YY QUAL QUAL. ТО 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

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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

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HEALTH INSURANCE CLAIM FORM

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

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

HEALTH INSURANCE CLAIM FORM

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

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