Mastering Medicaid Billing in Federally Qualified Health Centers (FQHCs)

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Introduction

About S4CH

Since 2007, Solutions 4 Community Health (S4CH) has focused on management solutions to meet the complex needs of our clients in response to the constant changing healthcare landscape. S4CH's expertise is in Strategic Consulting, Practice Transformation, Revenue Cycle Enhancement, Analytics, HEDIS and Risk Contracting Performance Improvements.

S4CH focuses its work primarily federally qualified health centers (FQHCs) and health care organizations that serve predominantly low-income, uninsured, and at risk populations.

S4CH Revenue Cycle Management

We optimize & maximize revenue, ensure accurate billing and coding, and streamline the financial processes within organizations. We utilize the use of automation to help optimize revenue cycle processes. We work hand in hand with our clients to ensure timely and efficient billing practices.

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CHCANYS Billing & Coding Webinar Series in Partnership with S4CH

1. ~~Basics of FQHC Billing 11/6/2024~~
2. Mastering Medicaid Billing in FQHCs 12/4/2024
3. Navigating Medicare Billing in FQHCs 1/8/2025
4. Provider Coding and Documentation 2/5/2025
5. Effective Claim Denial Management 3/5/2025

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Outline-Mastering Medicaid Billing in FQHCs

- ✓ **Establishing NYS FQHCs**
- ✓ **Provider Enrollment**
- ✓ **Reimbursement Models**
- ✓ **Revenue Cycle Process**
  - **Eligibility**
  - **Claim Submission**
  - **Claim Status**
  - **835/Remittance Advice**
- ✓ **Telehealth Billing**
- ✓ **Covered Services**
- ✓ **Office on Medicaid Inspector General (OMIG) Self Disclosure**

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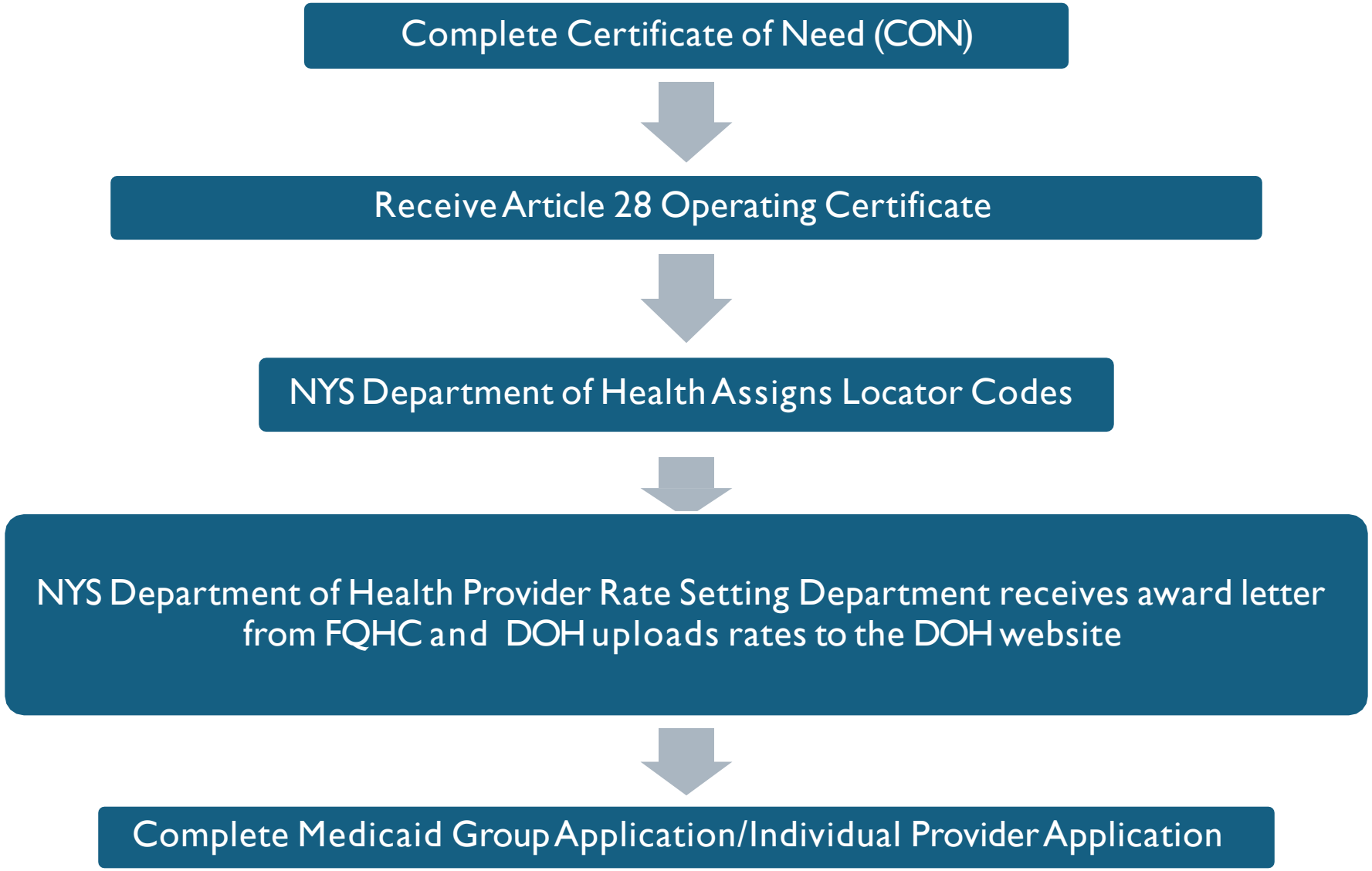
Establishing FQHC Article 28 Status in NY Medicaid



FQHC License Types

- **Article 28 Facility,** is an accredited medical facility that provides a range of services, including medical, dental, and behavioral health.
  - Article 28 health centers are regulated by the New York State Department of Health (NYSDOH).
- Additional NYS licenses found in FQHCs:
  - **Article 31 Facility**: Focus on behavioral health services regulated by the Office of Mental Health (OMH).
  - **Article 32 Facility**: Specialize in substance use disorder services under the Office of Addiction Services and Supports (OASAS).
  - **Article 16 Facility:** Specialize in providing services for individuals with intellectual or developmental disabilities. Regulated by the Office for People with Developmental Disabilities (OPWDD)

Group and Provider Enrollment

Process for NYS Medicaid Group Enrollment in an FQHC

Complete the Electronic Transmitter Identification Number (ETIN) Certification Statement (Must be revalidated every year and required on claim submission)

- https://www.emedny.org/info/providerenrollment

Process for NYS Medicaid Provider Enrollment in an FQHC

1. **Obtain a National Provider ID (NPI) (If one does not already exist)**
   - Go to the NPPES website https://nppes.cms.hhs.gov
2. **Submit an Enrollment Application for Your Provider Type**
   - Go to the Provider Index page.
3. **Application Review by NYS DOH**
4. **Notification of Determination by NYS DOH**
5. **Link NPI to FQHC on eMEDNY**
   - **https://npi.emedny.org/**
6. **Revalidation (Every five years for providers)**

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Medicaid Provider Types

Article 28	Article 31	Article 32
• Physicians • Physician Assistants (PAs) • Nurse Practitioners (NPs) • Licensed Midwives (LMs) • Licensed Clinical Social Workers (LCSWs) • Licensed Master Social Workers (LMSWs) • Licensed Mental Health Counselors (LMHCs) • Licensed Marriage and Family Therapists (LMFTs) • Dentists/Dental Hygienists • Psychologists • Optometrist/Opticians • Physical Therapists (PTs)/Occupational Therapists (OTs)/Speech-Language Pathologists (SLPs) • Podiatrists • Registered Dietitians	• Physicians • Physician Assistants (PAs) • Nurse Practitioners (NPs) • Licensed Clinical Social Workers (LCSWs) • Licensed Master Social Workers (LMSWs) • Licensed Mental Health Counselors (LMHCs) • Licensed Marriage and Family Therapists (LMFTs) • Licensed Clinical Art Therapist (LCAT)	• Physicians • Physician Assistants (PAs) • Nurse Practitioners (NPs) • Licensed Clinical Social Workers (LCSWs) • Licensed Master Social Workers (LMSWs) • Licensed Mental Health Counselors (LMHCs) • Licensed Marriage and Family Therapists (LMFTs) • Licensed Clinical Art Therapist (LCAT) • Credentialed Alcoholism and Substance Abuse Counselor (CASAC)

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Poll Question

Do you know how to locate and download your rates from the DOH website?

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Medicaid Reimbursement Types

- Ambulatory Patient Group (APG)
- Prospective Payment System (PPS)
- Ordered Ambulatory
- Supplemental Reimbursement-Wrap Around Payment and Court Ordered Rate Codes

Ambulatory Patient Groups (APG)

- APG is a Medicaid reimbursement classification system utilized for the reimbursement of a facility's cost of outpatient care.
- The Medicaid APG reimbursement methodology classifies and assigns any procedure code submitted for reimbursement. The reimbursement under APG is driven by this classification methodology.
- FQHCs have the option of opting in or out of APG.
- Main APG Classifications:
  - Significant Procedure
  - Medical Visit
  - Ancillary Procedure Classification

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APG Rate Codes

APG RATE CODES		
A28 SERVICE	VISIT RATE CODE	EPISODE RATE CODE
GENERAL CLINIC	1407	1422
GENERAL CLINIC APG MR/DD (EDIT EXEMPT)	1498	1495
GENERAL CLINIC MR/DD/TBI	1435*	1425*
SCHOOL BASED HEALTH PROJECT	1447	1453
A32 SERVICE	VISIT RATE CODE	EPISODE RATE CODE
FREE–STANDING ARTICLE 32 CLINIC	1540	
OASAS – ARTICLE 32 CLINIC MEDICAL VISIT	1468	
OASAS – ARTICLE 32 OUTPATIENT REHAB	1573	
OASAS – ARTICLE 32 OP REHAB MEDICAL VISIT	1570	
OASAS – FREE–STANDING OPIOID TREATMENT PROGRAMS (OTP)	1564	
OASAS – OTP CLINIC MEDICAL VISIT	1471	
A31 SERVICE	VISIT RATE CODE	EPISODE RATE CODE
OMH – FREE–STANDING ARTICLE 31 CLINIC	1504	
OMH – FREE–STANDING ARTICLE 31 CLINIC – OFF–SITE	1507	
OMH – FREE–STANDING ARTICLE 31 CLINIC – OFF–SITE (SED)	1513	
OMH – FREE–STANDING ARTICLE 31 CLINIC (CRISIS)	1579	
OMH – FREE–STANDING ARTICLE 31 CLINIC (CRISIS) (SED)	1585	
OMH – FREE–STANDING ARTICLE 31 CLINIC (SED)	1510	

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Prospective Payment System (PPS)

- Reimbursement based on revenue or rate codes billed.
- Full PPS payment for threshold visits.
- All inclusive payment for all services rendered on a particular date of service.
- One PPS payment is made per service date with the following exceptions:
  - *Medicaid*-A behavioral health visit and a medical visit on the same day qualifies for two separate PPS payments as long as two different rate codes are billed.

    *Example-one service in A28 on the same day as A31 or A32.

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PPS RateCodes

A28	RATE CODE
FQHC GROUP PSYCHOTHERAPY	4011
FQHC OFF–SITE SERVICES (INDIVIDUAL)	4012
FQHC INDIVIDUAL THRESHOLD VISIT	4013
SUPPLEMENTAL/WRAP	1609
COURT ORDERED	4028
COURT ORDERED OFF SITE	4027

A31	RATE CODE
INDIVIDUAL	4301
GROUP	4303
OFF-SITE	4306
GROUP PSYCHOTHERAPY - COURT MANDATED	4026
COURT ORDERED	4028

A32	RATE CODE
INTAKE	4273
INDIVIDUAL	4274
GROUP	4275

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Ordered Ambulatory

- FQHCs may bill an ordered ambulatory claim for certain specific services that are carved out from the all-inclusive PPS payment.
- Ordered ambulatory services may be covered and reimbursed on a fee-for-service (FFS) basis in accordance with the State medical fee schedule to test, diagnose or treat the patient.
- Common services billed to ordered ambulatory are laboratory services, radiology, electrocardiograms, ultrasounds, immunizations and intrauterine devices (IUD).
- Providers must be linked to the organization's Electronic Transmitter Identification Number (ETIN) in order to receive payment.

Vaccines For Children Program (VFC)

- Provides vaccines at no cost to eligible children under 19 years of age.
- Providers reimbursed for the vaccine administration only.
- Modifier SL must be used on the vaccine CPT code to indicate vaccine was acquired under the Vaccine for Children program.
- Bill CPT code 90460 for the administration of the vaccine to Medicaid. Reimbursement is determined by the Medicaid Ordered Ambulatory Fee Schedule.

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Family Planning

- Long Acting Reversable Contraceptives (LARC)
  - Intrauterine devices (IUDs) and contraceptive implants are carved out from the PPS payment.
  - A separate claim is billed for IUDs and contraceptive implants to Medicaid Ordered Ambulatory for fee for service reimbursement when billed with IUD insertion CPT on same day. LARC fees are covered at cost by Medicaid.
  - Must bill with modifier UD if purchased under 340b program.
  - Medicaid Covered LARC CPT Codes

CPT Code	CPT Description
J7296	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM
J7300	INTRAUTERINE COPPER CONTRACEPTIVE
J7301	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM
J7306	LEVONORGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM

PPS and Ordered Ambulatory Billing and Payment Scenarios

Service Rendered	Billing Guidance
Patient has an office visit only	This is a qualifying threshold visit and is reimbursed at the clinic rate
Patient has an office visit and an receives a vaccine(s) or insertion of a covered LARC	A claim is submitted to Medicaid for full PPS reimbursement for the office visit. A claim is submitted to Medicaid Ordered Ambulatory for the vaccine or covered LARC. The Vaccine or LARC is reimbursed at acquisition cost by Medicaid
Patient seen for vaccine (supported by Medicaid bulletin to bill to Ordered Ambulatory) only.	A claim is submitted to Medicaid Ordered Ambulatory for the acquisition cost of the vaccine as well as FFS reimbursement for the administration. The claim needs to be billed with the vaccine HCPCS code and the vaccine administration CPT code
Patient seen for insertion of LARC only	Claim is billed to Medicaid for PPS rate for the insertion CPT code 58300 and a claim is submitted to Medicaid Ordered Ambulatory for the acquisition cost of the LARC

Supplemental FQHC Payments

- Medicaid supplemental payments ensure FQHCs are fully reimbursed for their services. If the payments from Medicaid Managed Care plan are less than the PPS rate, Medicaid makes up the difference through supplemental or “wraparound” payments.
- FQHCs are reimbursed their full PPS rate when the Medicaid Managed Care plan denies a claim. These claims are submitted to Medicaid with a 4028 rate codes.
- The supplemental and court ordered claims are submitted directly to Medicaid for payment.
- Essential plans Tier 3 and 4 are also eligible for supplemental payments. Essential plans Tier 1-2 are not eligible for supplemental payments.
- FQHCs must complete the Managed Care Visit and Revenue (MCVR) report annually.

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Managed Care Visit Rate (MCVR)

The MCVR report includes the following information:

- Each contracted Managed Care Organizations (MCOs)
- The number of visits paid by each MCO/ Independent Practice Association (IPA)
- The average payment per visit from each MCO/IPA
- The blended Medicaid rate
- Unpaid visits and/or visits and revenue that occur outside a managed care contract

DOH Policy-https://www.health.ny.gov/health_care/medicaid/rates/fqhc/fqhc_policy_document.htm

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Managed Care Visit Rate (MCVR) Calculator

FFS Rates		Visits	Weighted Revenue
4011-Group Psych	$40.00	0	**$0**
4012-Individual Off-Site	$70.00	5,000	**$350,000**
4013-Threshold (PPS)	$250.00	15,000	**$3,750,000**
Weighted Average	$205.00	**20,000**	**$4,100,000**
Managed Care Average	$80.00		
Supplemental Rate	**$125.00**		

FFS Rates		Visits	Weighted Revenue
4011-Group Psych	$40.00	0	$0
4012-Individual Off-Site	$70.00	10000	$700,000
4013-Threshold (PPS)	$250.00	30,000	**$7,500,000**
Weighted Average	$205.00	**40,000**	**$8,200,000**
Managed Care Average	$100.00		
Supplemental Rate	**$105.00**		

MCVR w/out 4012 Visits

FFS Rates		Visits	Weighted Revenue
4011-Group Psych	$40.00	0	$0
4012-Individual Off-Site	$70.00	0	$0
4013-Threshold (PPS)	$250.00	30,000	**$7,500,000**
Weighted Average	$250.00	**30,000**	**$7,500,000**
Managed Care Average	$100.00		
Supplemental Rate	**$150.00**		

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Poll Question

Do you complete the MCVR internally or outsource?

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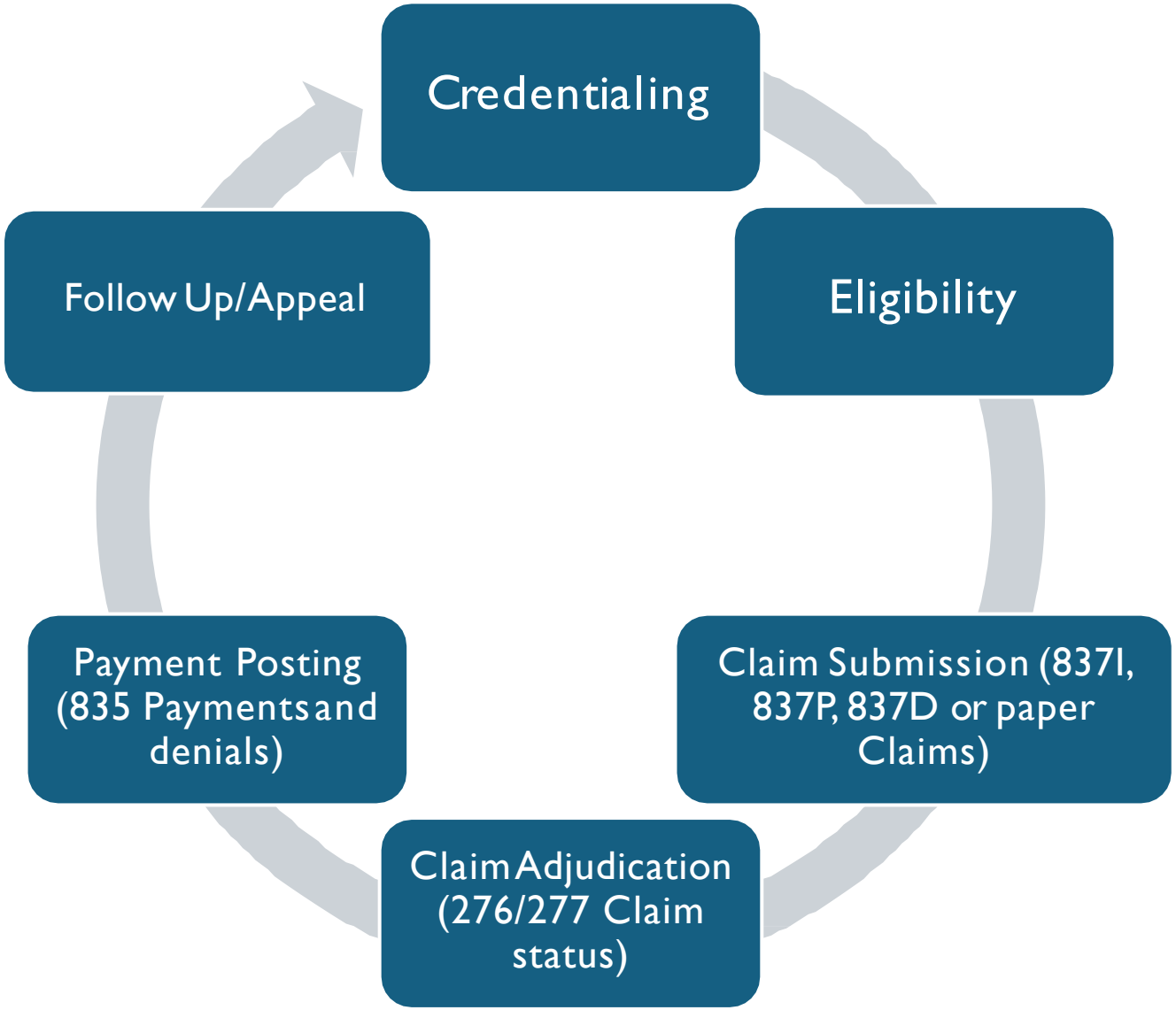
Medicaid Revenue Cycle Process



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Eligibility

- **Requirements to Verify Eligibility:**
  - Client Identification Number (CIN)
  - OR Social Security Number, Date of Birth, First/Last Name, and Gender
- **Sources to use for checking NYS Medicaid eligibility:**
  - ePaces
  - Clearinghouse
  - EMR system with integrated eligibility

Specific NYS Medicaid Eligibility Responses

- Medicaid Eligible
- Family Planning Only
- Emergency Services Only
- Transportation Services Only
- Medicare Co-Insurance and Deductible Only
- Community-Based Long Term Care Only
- Restricted Patient
- Presumptive Eligibility (PE)

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Claim Submission

- **Determine How You Will Submit Claims to eMedNY**
  - Option 1: HIPAA Compliant Claim Formats Submitted via Clearinghouse to eMedNY
    - HIPAA-compliant 837 Professional (837P), Institutional (837I), 837 Dental (837D)
  - Option 2: Medicaid's Electronic Provider Assisted Claim Entry System (EPACES) Web-Based Application to bill direct to eMedNY
    - Claims: Professional (real-time* or batch**) Institutional and Dental
  - Option 3: Paper Claim Forms
- **Claim Types**
  - Institutional Claims UB04
  - Professional HCFA
- **Bill Types/Type of Bill (TOB)**
  - 731 Original Claim
  - 737 Replacement of prior claim (adjustment)
  - 738 Void/cancel prior claim
- **Rate Codes**
- **Delay Reasons**

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Timely Filing for NYS Medicaid

- 90 days - Claims for payment of medical care, services, or supplies to eligible beneficiaries must be initially submitted within 90 days of the date of service.
- 60 days - Claims with errors or requiring documentation must be corrected/resubmitted within 60 days of notification.
- 30 days - Claims outside the control of the provider must be submitted within 30 days of coming within their control.
- 2 years- Claims must be finally submitted within 2 years.

https://www.emedny.org/providermanuals/allproviders/Guide_to_Timely_Billing.pdf

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Medicaid Delay Reasons

HIPAA Delay Reasons with numeric codes Claims aged over 90 days from the date of service or adjusted claims within 60 days from notification may be submitted if the delay is due to one or more of the following conditions.:

1 Proof of Eligibility Unknown or Unavailable
2 Litigation
3 Authorization Delays
4 Delay in Certifying Provider
5 Delay in Supplying Billing Forms
6Delay in Delivery of Custom-made Appliances
7 Third Party Processing Delay
8 Delay in Eligibility Determination
9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10 Administrative Delay in the Prior Approval Process
11 Other
15 Natural Disaster

https://www.emedny.org/providermanuals/allproviders/pdfs/information_for_all_providers-general_billing.pdf

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Medicaid Secondary/Tertiary

Here are some things to know about billing New York State (NYS) Medicaid as secondary insurance in a Federally Qualified Health Center (FQHC):

- **Claims submission and Reimbursement**: Claims must be submitted to Medicare and/or other Third-Party Insurance before being submitted to Medicaid. FQHC's are to be paid up to the **full PPS rate** after primary insurers' claims adjudicate.
- **Supplemental payments**: Effective January 1, 2022, FQHC's are entitled to receive full supplemental wrap payment when Medicaid Managed Care Plan is secondary.
- **Dually Eligible Individuals**: Medicaid pays the difference between Medicare payment and the FQHC's PPS Rate.
- **Zero-Fill Reimbursement**: Providers may bill Medicaid directly without first submitting claim to Medicare, for items that are not statutorily covered by the Medicare program.

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Claim Status and 835 Response

- **eMedNY**
  - Ability to obtain 277 response files (claim status)
  - Obtain 835 files with payments and denials
- **Common Medicaid Insurance Rejections**
  - Invalid CIN
  - Claim out of balance
  - Coordination of benefits not matched
  - Invalid Medicaid Provider ID
  - Invalid NPI
- Invalid Service/Billing address
- **Medicaid Insurance Denials**
  - Claim Adjustment Reason Codes (CAS)/Remark Codes

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CAS/REMARK CODES

29	Timely Filing (29)
B1, N30	Non covered visit, Patient ineligible for this service
22, MA04	This care may be covered by another payer per coordination of benefits.
45	Charge exceeds fee schedule/maximum allowable or contracted fee arrangement
96, N198	Rendering provider must be affiliated with the pay-to provider.
97, M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
16, MA39	Missing/incomplete/invalid gender. (16, MA39)
200	Expenses incurred during lapse in coverage (200)
243	Services not authorized by network/primary care provider
24	Charges are covered under a capitation agreement/managed care plan.

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Poll Question

Do you submit Medicaid Managed Care secondary for supplemental payment?

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Telehealth Definitions

- **Originating Site**-where the NYS Medicaid member is located at the time health services are delivered by means of telehealth.
- **Distant Site**-the site where the telehealth provider is located while delivering health services by means of telehealth.
- **Audio-Visual Telehealth**-uses two-way synchronous electronic audio-visual communications to deliver clinical health care services.
- **Telephonic (Audio-only)-**two way electronic audio-only communications to deliver healthcare services.

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Billing for Telehealth by Site and Location

Facility/Clinic Type	On-Site Presence	Billing Instructions
Article 28 D&TCs and FQHCs opting into APGs	Only the provider is on-site.	Provider submits APG claim for services provided.
	Only the NYS Medicaid member is on-site.	Provider submits APG claim for services provided. If the off-site provider delivering service is not employed or contracted by the facility, submit APGs for CPT code "Q3014" as originating site fee
	Neither the provider nor the NYS Medicaid member is on-site.	Physician can bill for Professional Component only.
FQHC Operated Article 28 that have not opted into APGs	Only the provider is on- site.	PPS Rate
	Only the NYS Medicaid member is on-site.	PPS Rate
	Neither the provider nor the NYS Medicaid member is on-site.	Off-site (**"4012"**) rate
FQHC Operated Article 31 (OMH Part 599) that have not opted into APGs	Only the provider is on- site.	Provider submits Article 31 rate coded claim for PPS rate (e.g., **"4301", "4303"**) with appropriate telehealth modifier (i.e., **95, GT, 93**).
	Only the NYS Medicaid member is on-site.	Provider submits Article 31 rate coded claim for PPS rate (e.g., **"4301", "4303"**) with appropriate telehealth modifier (i.e., **95, GT, 93**).
	Neither the provider nor the NYS Medicaid member is on-site.	Provider submits Article 31 rate coded claim for PPS rate (e.g., **"4301", "4303"**) with appropriate telehealth modifier (i.e., **95, GT, 93**).
FQHC Operated Article 32 (OASAS Clinic) that have not opted into APGs	Only the provider is on- site.	Provider submits Article 32 rate coded claim for PPS rate (e.g., **"4273"** through **"4275", "4214"** through "4216") with appropriate telehealth modifier (i.e., **95, GT, 93**).
	Only the NYS Medicaid member is on-site.	Provider submits Article 32 rate coded claim for PPS rate (e.g., **"4275", "4214"** through "4216") with appropriate telehealth modifier (i.e., **95, GT, 93**).
	Neither the provider nor the NYS Medicaid member is on-site.	Provider submits Article 32 rate coded claim for PPS rate (e.g., **"4275", "4214"** through "4216") with appropriate telehealth modifier (i.e., **95, GT, 93**).

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FQHC Telehealth Billing

- Place of Service (POS) codes
  - **POS 02**-Telehealth provided other than in the home of the patient.
  - **POS 10**-Telehealth provided in the home of the patient
  - **POS 11**-Telehealth provided in a private practice or office setting

- Required modifiers
  - **95**-audio-visual
  - **93 or FQ**-audio-only

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Office of the Medicaid Inspector General (OMIG) Self-Disclosure Program

- The Self-Disclosure Program requires Medicaid Entities, including enrolled Providers, Medicaid Managed Care Organizations (MMCOs), and others involved in billing or receiving Medicaid funds, to self-report overpayments.
- The Self-Disclosure Program addresses potential fraud, waste, abuse, or inappropriate payments identified through self-review, compliance programs, or internal controls.
- Medicaid Entities/Providers must report, return, and explain any identified overpayments to the Office of Medicaid Inspector General (OMIG) within 60 days of identification or by the due date of any related cost report, whichever is later.
- The lookback period for self-disclosure is six years by date of service.

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Self-Disclosure Program Process

- There are two distinct processes to report, return and explain self-identified overpayments:
  - Full Self-Disclosure Process
    - Submit Full Self-Disclosure Statement Form
    - Certification Form
    - Claims Data Form
  - Abbreviated Self-Disclosure Process
    - Submit Abbreviated Self-Disclosure Statement Form
- Examples of self-disclosure on the Full Self-Disclosure Statement
  - Examples of self-disclosure on any error that requires a Medicaid entity/Provider to create and implement a formal corrective action plan
  - Documentation errors that resulted in overpayments
  - Overpayments that resulted from software or billing system updates
- Abbreviated Self-Disclosure Statement
  - Routine credit balance/coordination of benefits overpayments
  - Typographical human errors
  - Inappropriate rate, procedure or fee codes used due to typographical or human error

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Important Resources

- **Learn Medicaid Billing Policies and Procedures**
  Emedny website
  https://www.emedny.org/
- **Sign-up for the Medicaid Update**
  - To receive the Medicaid Update via email in PDF format, send an email requesting including your MMIS Provider ID Number to medicaidupdate@health.ny.gov
  - https://www.health.ny.gov/health_care/medicaid/program/update/main.htm
- **Find Organization NYS Department of Health FQHC Rate Code File:**
  https://www.health.ny.gov/health_care/medicaid/rates/fqhc/fqhc_rates.htm
- **Check status of your Medicaid Enrollment Application:**
  https://www.emedny.org/info/providerenrollment/managedcarenetwork/index.aspx
- **OMIG Self Disclosure Information:**
  https://omig.ny.gov/self-disclosure-frequently-asked-questions

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Thank You

Questions

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