FQHC Payment Methodology: Frequently Asked Questions

1. How should FQHCs submit the third quarter wrap payments?

Wrap requests for dates of service prior to 10/1/2016 should be submitted to Fred Hoeflinger. FQHCs should submit dates of service in September in a separate file (spreadsheet), and dates of service prior to September 1st will continue to be bundled together.

2. Will DHCF revisit claims submitted prior to 9/1/16?

DHCF will not apply its new policy for encounters prior to 9/1/16.

3. How will visits for procedures such as colposcopies, IUD insertions, lacerations, etc., that are conducted by qualified practitioners as defined in the SPA and rule, be handled?

For the procedures listed below, FQHCs should submit these for wrap payment and include the CPT code and the T-1015SE code.

Abscess incision and drainage 10060 and 10061, or 10030
Colposcopy 57455
Contraceptive, implant system J7307
Insertion of IUD 58300
Insertion, non-biodegradable drug delivery implant 11981
Joint aspiration/injection 20600, 20605, 20610
Mirena J7298
Paragard J7300
Removal of IUD 58301
Removal with Reinsertion, non-biodegradable drug delivery implant 11983
Removal, non-biodegradable drug delivery implant 11982
Skin biopsy 11100
Skin tag removal 11200
Toenail removal 11750
Levonorgestrel releasing Intrauterine contraceptive system 13.5 mg J7301

4. **How should FQHCs bill for substance use disorder (SUD) services rendered?**

Only FQHCs with certification from DBH can bill for DHCF for SUD services rendered. DHCF is in the process of working with Xerox to program the MMIS system so that FQHCs can bill for MCO beneficiaries' SUD services through MMIS (these services will NOT be billed through the MCOs). DHCF will have this process completed by December 2016, and further guidance will be issued at that time.

Please note that DBH will be amending the contracts of those FQHCs that are ASARS providers, such that clinical care coordination will be removed as a reimbursed service (since care coordination is a service covered through DHCF's APM rate).

For FQHCs that are ASARS providers, FQHCs will be allowed to either bill DBH as certified providers if they have a Human Care Agreement with DBH *OR* bill under the new APM.

5. Who is the point person at DHCF that each clinic should call if problems arise with sending claims over?

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6. What NPIs and taxonomy codes are needed?

Providers will need an NPI code for *each* site, and each NPI will have up to 3 taxonomy codes (i.e., primary care, behavioral health, and dental).

7. Will MCOs require the new NPI and taxonomy codes?

The MCOs will require the new provider IDs. DHCF's Operations team will work with HCDMA to ensure the IDs are given to the health plans.

8. When must an FQHC start using the new codes?

The SPA and rule for the FQHC payment methodology establishes new payment rates effective September 1, 2016. However, not all providers have received their new NPI numbers or taxonomy codes. Therefore, the Medicaid Director has authorized a transition period. FQHCS will have until September 30 to begin using the new NPIs and taxonomy numbers.

9. Why must FQHCs use the new NPI numbers and taxonomy codes for billing?

Once the SPA is approved, DHCF will reprocess all claims using the new rate methodology. Claims paid using the "old" Medicaid NPI will be reversed and DHCF will recoup the funds. FQHCs will then need to resubmit the claims using the new provider numbers and taxonomy codes. To avoid having to pay back and then rebill these claims, DCHF is requiring providers to use the new provider NPIs and taxonomy codes no later than September 30, 2016.

10. How should providers bill encounters during the transition period?

From September 1-September 30, FQHCs may bill under their "old" Medicaid provider number and DHCF will pay the interim rate.

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11. How should FQHCs address these transition period encounters once the SPA is approved?

Once the SPA is approved, FQHCs will have to resubmit the claims that were submitted using their existing Medicaid provider number if the services were for dental or behavioral health; these payments will be reversed and the claims will be rebilled using the new taxonomy. FQHCs should also include the HCPCS codes for the services provided during the encounter. This will expedite the process when claims are reprocessed after the SPA is approved.

12. Which rate should FQHCs bill as of September 1, 2016?

FQHCs should bill the interim rate, per the current SPA. Alternatively, the FQHCs may bill an amount that is different than the interim rate and will be paid the lower of the two. By billing a rate that is lower than the interim rate, an FQHC may reduce the amount that the FQHC will owe DHCF once the SPA is approved and claims are reprocessed under the new rates. FQHCs should carefully consider their options when determining what rate to bill.

13. How should FQHCs handle same day billing and reconciliations?

Once the new APM policy is effective after the SPA is approved by CMS, FQHCs that opt to receive the APM will be able to submit up to three types of claims for services provided to a single beneficiary per day: primary care, behavioral health and dental (either preventive & diagnostic or comprehensive; if both are provided, FQHCs will be reimbursed at the comprehensive rate). Until the SPA is approved, FQHCs should plan to submit all claims that comport to the proposed APM policy. DHCF will only pay for the first claim received, and others will be denied. After the SPA is approved, DHCF will reprocess all the claims and reimburse appropriate same day claims that were previously denied.

14. How should wrap claims be processed?

FQHCs will submit their wrap payment requests as they would a regular FFS claim where Medicaid is the secondary payer with the addition of procedure code T1015-SE. When the FQHC submits their wrap payment request in the new process it will be an 837 file that includes the MCO paid amount in the COB segment of the 837 record. We will treat each claim as a wrap payment if the following occurs:

- The beneficiary is active and enrolled in an MCO
- There is an encounter for the same NPI and date of service
- The MCO paid amount from the encounter matches the third party liability (COB) amount on the wrap request.

If the system does not find a match on the second two bullets, the claim will pend for 30 days and then the request will deny. Wrap payment related claims will be reported on the FQHCs remittance advice with an indicator to flag the wrap requests.

15. Regarding the changes to wrap processing, when do we start submitting on a weekly basis, September or October? Does DC Medicaid want all wrap in one billing file for a given week?

FQHCs may begin submitting weekly files for dates of service after 10/1/2016 as soon as they receive the payment from the MCOs. Until the system is updated to process the wrap payments

and the state plan changes are approved, these claims will deny as an MCO covered service. After the SPA is approved, DHCF will reprocess these claims and calculate the wrap payment.

16. How are FQHCs expected to submit wrap claims with dates of services prior to 10/1/16 that would have been submitted on the quarterly report?

FQHCs should submit wrap claims with dates of service prior to 10/1/16 via spreadsheet to Fred Hoeflinger.

17. Should FQHCs submit the T1015 SE and CPT/CDT for actual services rendered to DC Medicaid AND to the MCOs?

The MCOs do not require or expect T1015-SE on their claims.

18. When will the MCO timely filing change from 180 to 365 days be implemented?

The new contracts to be awarded October 2017 will mandate that MCOs allow that claims be filed within 365 days of the date of service.

19. Can MCOs be required to update individual FQHC contracts?

The provider agreements between the MCO and FQHCs can be amended at the discretion of the MCO, but if they choose to do so – this must be waived by DHCF/OCP because of the language in the contract: "Timely Processing of Claims: Providers shall submit claims no later than one hundred eighty (180) days from the date of service."

20. Are there any requirements for FQHCs that bill under the "behavioral health" taxonomy number?

DC law requires that entities providing substance abuse services be certified by DBH (see language below from *Title 44. Charitable and Curative Institutions, Subtitle 1. Health Related Institutions, Chapter 12. Substance Abuse Treatment and Prevention*). DHCF is working with DCPCA and DBH to better understand this requirement and its operational implications for FQHCs.

> § 44-1204. Certification requirements
> (a) Any public or private person, partnership, corporation, association, charitable organization, or other legally-constituted entity, whether for profit or not for profit, that provides or offers to provide nonhospital residential or outpatient treatment for substance abuse shall be certified by the Mayor as a condition of operation and shall operate in compliance with the standards necessary to maintain certification. The Mayor may certify a facility as qualified to provide nonhospital residential treatment, outpatient treatment, or both.

21. How should FQHCs handle wrap payments for multiple visits related to a global payment?

After the FQHC submits and is paid for the global payment, the FQHC should submit the wrap payment to DHCF following the wrap payment submission process with the from and thru dates as the start and end date of the global process, the number of units on the T1015-SE line equal to the number of interim

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visits and the other insurance amount would be the global payment from the MCO. The system will calculate the FFS equivalent by multiplying the number of units by the FQHC encounter rate. As with other wrap payment requests, if the MCO paid amount is less than the FFS rate the wrap amount will be the difference between both rates. If the MCO paid amount is greater than or equal to the FFS rate there will be no additional payment to the FQHC. Please see the example below that assumes an FQHC encounter rate of $300 and an MCO payment of $1,200 for the global procedure.

A beneficiary needs dentures and has several visits as a part of the process between September 2 and November 20, 2016.

From and Thru Dates	Procedure code	Units	FFS Rate	FFS Rate	Wrap Amount
9/2/2016 – 11/20/2016	T1015-SE	3	$300	$900	$0
9/2/2016 – 11/20/2016	T1015-SE	4	$300	$1200	$0
9/2/2016 – 11/20/2016	T1015-SE	5	$300	$1500	$300

For FQHCs with capitated arrangements with an MCO, the FQHCS will continue to submit their claims to the MCOs that will result in $0 pay claims that are passed to DHCF. The FQHCs will submit wrap payment claims with $0 as the other insurance amount. The system will calculate a wrap payment for those encounters. DHCF will develop a form for the FQHCs to report their monthly capitation amount. DHCF will create an offset equal to the capitation payment.

Note: This process assumes that FQHCs do not submit claims to the MCO for the interim visits related to a global procedure like dentures but submit each encounter on as a request for a wrap payment.

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