Mercy Care Plan Mercy Care Advantage HMO SNP

Provider Notification
Federally Qualified Health Centers (FQHC) Prospective Payment System Implementation

Date of Notification	**March 9, 2015**	**Revision Date**	**September 1, 2015**
Plans Affected	**All Lines of Business**		

Effective 4/1/2015, AHCCCS, along with Mercy Care Plan, will begin paying FQHCs an all-inclusive per visit PPS rate on a per claim basis, which replaces the current methodology of reimbursing claims through a fee for service methodology. This will affect Mercy Care Advantage as well.

FQHCs and FQHC Look-Alikes will need to re-register under the provider type of C2 and obtain a unique NPI number not already associated with another active AHCCCS provider ID for each clinic covered by the CMS FQHC, FQHC-LA or RHC designation. The new NPIs will be used for claim submissions beginning with dates of service on or after 4/1/15. A new NPI can be obtained at: **https://nppes.cms.hhs.gov/NPPES/Welcome.do**.

Per AHCCCS, an FQHC/RHC Visit is defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

Mercy Care Plan Billing

Beginning 4/1/2015, all FQHC, FQHC-LA, and RHC visits must be billed using the Form 1500 (02-12) or the 2012 ADA Form. For purposes of reimbursing visits beginning 4/1/2015, Mercy Care has adopted HCPCS code **T1015** – *Clinic visit/encounter, all-inclusive* for reporting physical health, behavioral health, and dental visits. A claim for a FQHC, FQHC-LA or RHC visit must include all appropriate procedure codes describing the services rendered in addition to HCPCS visit code T1015.

A visit will be identified by, and reimbursement for the visit will be associated with, HCPCS code T1015; all other services reported on the claim will be bundled into the visit and valued at

$0.00. T1015 is reimbursable at the established AHCCCS PPS rate for each FQHC and should be billed using that rate.

Mercy Care Advantage Billing

Beginning 4/1/2015, all FQHC, FQHC-LA, and RHC visits must be billed using the UB-04 Form. A visit will be identified by, and reimbursement for the visit will be associated with the following HCPCS codes; all other services reported on the claim will be bundled into the visit and valued at $0.00. Current reimbursement rates for the following codes are as follows:

- Established patients - $89.00 per visit
- New patients - $105.00 per visit

For purposes of reimbursing visits beginning 4/1/2015, Mercy Care Advantage will be using Medicare specific codes as follows:

- **G0466** – *Federally qualified health center (FQHC) visit, new patient; a medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit*
- **G0467** - *Federally qualified health center (FQHC) visit, established patient; a medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit*
- **G0468** – *Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV*
- **G0469** – *Federally qualified health center (FQHC) visit, mental health, new patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit*
- **G0470** – *Federally qualified health center (FQHC) visit, mental health, established patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.*

Certain services are not considered FQHC services either because they are 1) not included in the FQHC/RHC benefit; or 2) are not a Medicare benefit. These services include:

- **Medicare Excluded Services** – This includes physical checkups, dental care, hearing tests, eye exams, etc. A full listing of Medicare excluded services can be found in the

Medicare Benefit Policy Manual – Chapter 16 – General Exclusions from Coverage under **Section 10 – General Exclusions from Coverage**.

Please Note: Mercy Care Advantage offers additional benefits that are not normally covered by traditional Medicare. Please refer to our **Additional Benefits** web page for detail regarding these services. While these are not part of the FQHC/RHC services, they should be billed and will be processed separately from FQHC.

- **Technical Component of an FQHC/RHC** – This includes diagnostic tests such as the technical component of x-rays, EKGs and other tests.
- **Laboratory Services** – This does not include venipunctures.
- **Durable Medical Equipment** – This include crutches, hospital beds and wheelchairs used in the patient's place of residence, whether rented or purchased.
- **Ambulance Services**
- **Prosthetic Devices**
- **Body Braces**
- **Practitioner Services at Certain Other Medicare Facility**
- **Tele-Health Distant Site Services**
- **Hospice Services**

The above services are not part of the FQHC/RHC services, and as such they should be billed and will be processed separately from the FQHC payment.

Dual Eligible Claims Billing

Since CMS billing requirements are different from AHCCCS billing requirements, we will require the initial claim sent to Mercy Care Advantage be billed according to the instructions above in the Mercy Care Advantage Billing section. Once you have received the remit, please rebill the service following billing instructions in the Mercy Care Plan Billing Section and submit with the Mercy Care Advantage remit you previously received. Claims must be billed in this fashion in order for us to properly encounter claims to our regulators.

Billing Resources

Additional information regarding FQHC PPS billing is available at the AHCCCS website as follows:

http://www.azahcccs.gov/commercial/FQHC-RHC.aspx

http://www.azahcccs.gov/commercial/PaymentShift.aspx

Additional information regarding FQHC PPS billing is available at the CMS website as follows:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html