GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director

Transmittal # 16-12

TO: Federally Qualified Health Centers (FQHCs)

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: April 25, 2016

SUBJECT: **New Billing and Enrollment Instructions to Federally Qualified Health Centers**

The following transmittal provides new billing and enrollment instructions to Federally Qualified Health Centers (FQHCs) to prepare them for proposed changes to the FQHC reimbursement methodology under the District's Medicaid program.

Background

Federal law requires FQHCs to be reimbursed under a prospective payment system (PPS) based on reasonable costs, pursuant to section 1902(bb) of the Social Security Act (42 USC § 1396 (bb). The current PPS reimbursement model was developed in 1999. Since that time, the number of FQHCs operating in the District and the volume and variety of patients served have increased. As a result, DHCF is preparing to issue an emergency and proposed rule to update the PPS methodology. The updated methodology will institute separate cost-based, facility-specific encounter rates for medical and behavioral services.

In addition, DHCF is preparing to issue a second emergency and proposed rule governing reimbursement of dental services. This new payment methodology will institute a separate, facility-specific encounter rate based on aggregate utilization of each FQHC's dental services.

While these rules will be pending review and approval until finalized, DHCF is instructing FQHCs to implement certain billing and provider enrollment adjustments consistent with the new requirements so that FQHCs are able to implement these requirements once final. FQHCs

must make these adjustments to any claims submitted for payment with dates of service beginning May 1, 2016.

Provider Enrollment

FQHCs may operate in one or more physical sites, with each site offering its own array of services to Medicaid beneficiaries. DHCF is instructing FQHCs to separately enroll each site for each of the core service categories the FQHCs plan to provide at that site: medical, behavioral, and/or dental. Specifically, the FQHCs must have a unique Medicaid provider ID for each site for each core service category. For example, if a hypothetical FQHC were to operate two different sites in the District, and the FQHC plans to bill for medical, behavioral, and dental services provided at both of those sites, that FQHC would require a total of six unique Medicaid provider IDs.

DHCF is also instructing FQHCs to ensure that each site has its own unique NPI number. In addition, the FQHC should identify core categories of services provided across sites with unique taxonomy codes. Each taxonomy code should be specific to a core category of service and consistent across sites. In the hypothetical example above, the FQHC would have two NPI numbers—one for each site—and use the same set of taxonomy codes—one for medical, one for behavioral, and one for dental—across those two sites.

To enroll additional sites, FQHCs should submit a DC Medicaid Institutional Application which can be found on the provider web portal at www.dc-medicaid.com. Please note FQHCs must pay an application fee of $554 for each additional site.

Claims Submission

DHCF plans to reimburse FQHCs for up to one encounter per day for each core service category. Each FQHC shall ensure that procedures that require a single course of action associated with a beneficiary's medical, behavioral, or dental treatment plan be completed as a single encounter unless multiple visits are required to complete the treatment plan.

When billing for an encounter, DHCF is instructing FQHCs to include all CPT/CDT codes related to the encounter. There must be one payable procedure on all claims for DHCF to pay the encounter rate. The claim should continue to be a complete record of all services provided.

DHCF also plans to pay for group therapy as a percentage of the behavioral PPS rate. FQHCs must include the group therapy procedure code (90853) when submitting group therapy encounters.

Submission of Data for Wrap-around Supplemental Payments

DHCF plans to continue to provide a wrap-around supplemental payment to FQHCs if the payment they receive from Medicaid Managed Care Organizations (MCOs) is less than the PPS rate. DHCF is instructing FQHCs to submit an EDI 837 file on a weekly basis to DHCF. The 837 file should contain the claims paid by the MCO with the amount paid by the MCO in the

TPL field on the 837 transaction. On a weekly basis, DHCF will process the claims file and pay the difference between the MCO payment and the PPS rate. DHCF will make no payments for any claims where the MCO payment is listed at $0, or the claim has been denied by the MCO. Claims denied by the MCO can be appealed to the MCO.

DHCF Contact

If you have any questions or require additional information, you may contact the DHCF Division of Public & Private Provider Services at 202-698-2000.