**MCO – FQHC/RHC Project Related Questions**

**2/12/2015 Update**

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| **Question Number** | **Question submitted by** | **Date submitted** | **Question** | **Response** |
| **1** | **CPSA** | 6/26/2014 | Do Provider Types 29 and C2 apply to behavioral health services or are they for the medical side only? | Yes. All for medical, dental, & behavioral health services as applicable to the individual FQHC/RHC. |
| **2** | **CPSA** | 6/26/2014 | If these Provider Types apply to behavioral health, will the rural health clinics have the IC Provider Type also? | See Question #1. No, if provider is an RHC than they will only be registered as a RHC. |
| **3** | **CPSA** | 6/26/2014 | Currently DBHS has restricted RBHAs from submitting multiple procedural line HCFA’s and this appears to require a multi-line HCFA. | Correct, we are aware of this restriction, has shared with BHS this concern and we are working with them on a resolution. |
| **4** | **CPSA** | 6/26/2014 | Questions on E&M codes | Please clarify the question, thank you. |
| **5** | **Health Net** | 6/26/2014 | Please advise whether the FQHC/RHC rates will be sent in a new file, or existing file. If existing- which file and will there be any layout changes? | No layout changes, but FQHC's/RHC's haven't historically been Provider Types included. Now they will be in both the Profile and Provider Extracts. |
| **6** | **Health Net** | 6/26/2014 | This new pricing method will be effective 10/1/2014 - it is assumed most providers will be registered with their new AHCCCS Provider ID and Provider Type (29/C2) by then. For those FQHC/RHCs that have not registered by 10/1/2014- are the MCOs (Health Net in this case) obligated to be able to identify FQHC/RHCs by NPI and price their claims according to this new fee schedule? If yes, what can be used to determine which NPIs are FQHC/RHCs? | At this time, it is our intent if a FQHC isn't properly registered, then they will not be paid. Just a reminder effective date has been revised to 4/1/2015. |
| **7** | **Health Net** | 6/26/2014 | May we please see sample of the unique provider specific fee schedule that AHCCCS is creating for FQHC and RHC. May we see the codes and rate structure? | AHCCCS examples developed and shared with Contractors in 10/15 workgroup. |
| **8** | **Health Net** | 6/26/2014 | Will AHCCCS provide us the providers' unique NPIs please? | Part of provider extract for the individually registered FQHC's/RHC's. |
| **9** | **Mercy Care** | 7/30/2014 | How will FQHCs/RHCs bill when the October 1, 2014 changes take effect? | FQHC/RHC providers will be required to bill on form 1500 or ADA form as appropriate using their NPI for the FQHC or RHC. Billing changes will be addressed in the FFS Provider Billing Manual. FQHC/RHC providers are expected to bill with standard coding for all services in addition to the reporting of the T1015 PPS visit code. Please note FQHC/RHC change effective date has been revised to 4/1/15. |
| **10** | **Mercy Care** | 7/30/2014 | If the FQHC is the rendering provider with its own NPI do we no longer need to track the individual practitioners who provided the service? | AHCCCS has outlined and distributed billing requirement for providers to utilize an identified field for the reporting of the "participating" provider on both the 1500 and ADA claim forms/file formats. |
| **11** | **Mercy Care** | 7/30/2014 | Can members be assigned to the FQHC instead of individual PCP practitioners? | No, members should be assigned to individual practitioners and they should be credentialed. |
| **12** | **Mercy Care** | 7/30/2014 | Can we eliminate the credentialing of individual practitioners affiliated with the FQHC? | No. Please refer to #11. |
| **13** | **Mercy Care** | 7/30/2014 | Start credentialing the FQHC as an Organization? | No. Please refer to #11. |
| **14** | **PHP** | 6/26/2014 | Will payment differ based upon provider type or NPI being billed? | Yes, FQHC/RHC providers will have Provider specific PPS rates. Please clarify if this is not the answer you were seeking. |
| **15** | **PHP** | 6/26/2014 | How and when these rates will be provided as well as what constitutes a ‘unique’ visit? | Rates have been released, and will be incorporated into AHCCCS production region Provider tables concurrent with the 4/1/2015 implementation. Refer to Visit Definition below - 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. |
| **16** | **PHP** | 6/26/2014 | We would need a clarification as there is reference to billing on a 1500 form for a facility. Typically a facility would bill on a UB form.  1. Contractor’s will need to pay FQHC/RHC unique PPS rates for each “visit” (separate service not with same discipline) --indicates each ‘visit’ as a separate service not of the same discipline. If the NPI of the FQHC or RHC is listed in the rendering provider field of a 1500 form and not that of the rendering provider, how would we determine different disciplines? | AHCCCS billing standard is 1500 or ADA form as appropriate. You are correct; the NPI in the rendering provider field is the FQHC or RHC. It is the diagnosis codes that define the discipline. |
| **17** | **PHP** | 6/26/2014 | Please could you provide further clarification on this bullet point: 1. FQHC and RHC claims will identify the unique NPI of the FQHC or RHC as the service/rendering provider? 2. Would this conflict with or change any of our contractual agreements with any of these providers? | Please clarify as needed. AHCCCS cannot speak to your individual contractual agreements with providers. |
| **18** | **PHP** | 6/26/2014 | Will there be any workgroup discussions regarding this project? | Technical Workgroup meetings are occurring on an ongoing basis as needed. |
| **19** | **PHP** | 6/26/2014 | How will capitated FQHC arrangements be affected by this requirement? (if we can no longer maintain capitation agreements with FQHC’s then it will effect contractual relationships) | Current capitation arrangements must be renegotiated to reflect requirements to pay PPS rates. |
| **20** | **PHP** | 6/26/2014 | Why the new Provider type codes- Provider types 29 and C2- why is AHCCCS not using 50 and 72 that already exist? Is this to facilitate switch in pricing protocols? | 50 & 72 are place of service, not provider types. Provider Types will trigger reimbursement at PPS visit rates. |
| **21** | **PHP** | 6/26/2014 | Will AHCCCS be issuing communication regarding any of the billing requirements identified in your e-mail to these providers in formal notification or website information? Can we anticipate that all plans will be processing using the same guidelines, if so it would be most appropriate to have AHCCCS issue provider notifications? | AHCCCS has an FQHC/RHC webpage specific to the payment process change - http://www.azahcccs.gov/commercial/PaymentShift.aspx. |
| **22** | **PHP** | 6/26/2014 | Can the plans be copied on any communication to the providers in preparation of this reimbursement change? | Yes, all information will be posted to the AHCCCS FQHC/RHC webpage noted above. |
| **23** | **PHP** | 6/26/2014 | Is there an existing status template for submitting monthly statuses for this implementation? | At this time, there are no requirements for routine Contractor status updates. |
| **24** | **United** | 6/26/2014 | Is there an AHCCCS ISD for this change that can be shared with MCOs? | AHCCCS will make available all PMMIS R&D documents for this project as requested by the Contactors. Please note changes within PMMIS other than the addition of the new provider types are limited. |
| **25** | **United** | 6/26/2014 | Are there new or changed provider/profile or reference tables? | There will be new Provider Profiles for the new Provider types and new provider specific rates added for the new Provider types to the existing Profile and Provider weekly layouts. |
| **26** | **United** | 6/26/2014 | Will there be new encounter edits/pends/rejections/denials setup? | Not anticipated at this time. |
| **27** | **United** | 6/26/2014 | Is there a proposed report layout for the payment and reconciliation? | If you are referring to the FQHC reconciliation, MCOs are not involved. If you are referring to the MCO revenue and expense reconciliation then the reconciliation policy in place today continue to apply. |
| **28** | **United** | 6/26/2014 | Can provide a table of the “appropriate CPT E&M codes, including all related services”. (Please reference www.azahcccs.gov/commercial/.../AHCCCSUpdateSystems42014.ppt) | Please clarify your question as needed. AHCCCS is currently completing the "test" build of the Provider Type profile and will share this with Contractors ASAP. |
| **29** | **United** | 6/26/2014 | How will COB and cost sharing be applied for claims that would otherwise be paid a PPS rate? If primary carrier leaves a deductible, coinsurance or copay – will we pay the entire remainder? Or just put to the PPS rate for all services listed on the primary carrier’s EOB? Any QMB exceptions? Any Dual exceptions? (ACOM 201) | With the exception as outlined below follow current COB policies and guidelines. The use of T1015 to trigger PPS payments under Medicaid will necessitate that providers follow new/specific billing instructions and that the MCO accept a mismatch between the claim and primary carrier EOB. |
| **30** | **United** | 6/26/2014 | Are there any special requirements for Dual-eligible members or differences in between Medicare and AHCCCS on PPS? | With the except as outlined below MCOs should continue to follow AHCCCS Medicare cost sharing policy. The use of T1015 to trigger PPS payments under Medicaid will necessitate that providers follow new/specific billing instructions and that the MCO accept a mismatch between the claim and primary carrier EOB. |
| **31** | **United** | 6/26/2014 | The Medicare payment for FQHC services must be 80% of the lesser of the actual charges or the PPS amount; does that same rule apply for AHCCCS? (lessor of logic) | With the except as outlined below MCOs should continue to follow AHCCCS Medicare cost sharing policy. The use of T1015 to trigger PPS payments under Medicaid will necessitate that providers follow new/specific billing instructions and that the MCO accept a mismatch between the claim and primary carrier EOB. |
| **32** | **United** | 6/26/2014 | Medicare – FQHCs may be required to use new payment codes (G-codes) to bill for an FQHC visit; does that also apply to AHCCCS? (G0466 – FQHC visit, new patient, G0467 - FQHC visit, est. patient, G0468 - FQHC visit, IPPE Or AWV, G0469 – FQHC visit, mental health, new patient, G0470 – FQHC visit, mental health, est. patient) | Due to feedback and discussions with the FQHC/RHC providers, AHCCCS intends to adopt HCPCS code T1015 for FQHC and RHC "visit" billing for physical, behavioral health, and dental "visit" billing. |
| **33** | **United** | 6/26/2014 | Are there exceptions to the single per day for subs. Illness or injury, mental health that occur on the same day? | Refer to Visit Definition below - 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. |
| **34** | **United** | 6/26/2014 | Are there any carve-out services from the rate? Such as ambulance, diagnostic tests, injectables, DME, labs? | Only pharmacy is carved out and it's paid 340B rates under a registered Pharmacy provider ID and NPI. |
| **35** | **United** | 6/26/2014 | What are the reconciliation periods and final encounter dates to ensure all encounters are adjudicated/approved? (What if encounters are adjusted/recouped beyond that time period (assume AHCCCS approved the recovery, of course!) | If you are referring to the FQHC reconciliation, MCOs are not involved. If you are referring to the MCO revenue and expense reconciliation then the reconciliation policy in place today continue to apply. |
| **36** | **United** | 6/26/2014 | MCO’s will need to pay FQHC/RHC unique PPS rates for each “visit” (separate service not with same discipline). What is the definition of a visit? Is it, for example a unique DOS? Are there any exceptions to the unique DOS; i.e. patient gets office visit, then goes home, and then comes back later the same day? Please define “same discipline” or provide a table of provider type and specialties considered the same discipline. If FQHC and RHC will get a unique provider id; will they bill all services under that ID as servicing provider in box 24J of CMS1500? If the statement above is true, how would separate services with different disciplines be identified on the claim? | See definition of a visit on # 33. |
| **37** | **United** | 6/26/2014 | If a one claim is billed for several DOS and each meets the criteria, can multiple PPS rates be paid on the same claim? | Yes, for each unique visit. See definition of a visit on #33. |
| **38** | **United** | 6/26/2014 | Is the PPS rate paid regardless of place of service? | Yes, based on provider type, not the place of service. |
| **39** | **United** | 6/26/2014 | Will all HIPPA editing still apply to the claim?(for example: CCI, MUE) | Yes, these are federal requirements. |
| **40** | **United** | 6/26/2014 | Please confirm that FQHC/RHC should continue to bill per HIPPA guidelines, in that, all appropriate services should be billed even if a per-visit payment is applied to the E&M code. For example: office visit with a vaccine administration and toxoid. | Yes, see #39. |
| **41** | **United** | 6/26/2014 | If non-E&M lines on the claim are not billed correctly, do they still get the PPS rate payment? i.e. office visit billed correctly, but VFC not billed correctly. | Yes, if one or more lines are in error, those lines should fail but lines that are not in error should adjudicate. |
| **42** | **United** | 6/26/2014 | If a service requires prior authorization, our PA rules still apply in that a per-visit payment does not override our plan requirements, correct? | Yes, PA rules may still apply. |
| **43** | **United** | 6/26/2014 | If a mid-level bills the service, do they still get 100% of the PPS rate? Or, does the provider receive a percent of the PPS rate? | The FQHC will be the rendering and paid at 100% at PPS rate. Individual practitioners including mid-levels will not bill for FQHC/RHC services or be paid the PPS rate. |
| **44** | **United** | 6/26/2014 | If the provider doesn’t bill an E&M service, what rate is paid? | E&M codes do not trigger PPS payment. If the T1015 payable code is not billed no PPS payment is made. |
| **45** | **United** | 6/26/2014 | What if the FQHC (non-contracted) sends in two claims for 2 different specialists; one billed an E&M service and gets paid the PPS rate; and one bills for a non-E&M services - - do they still get paid? If so, what would be the AHCCCS FFS rate? | As with all providers, if the FQHC is non contracted, you are not obligated to pay. Individual practitioners including mid-levels will not bill for FQHC/RHC services or be paid the PPS rate. |
| **46** | **United** | 6/26/2014 | If the physician is doing E&M services in POS21, 22, or 24, and not in the FQHC place of service but with an FQHC NPI or TIN, does they still get the PPS rate? | Individual practitioners including mid-levels will not bill for FQHC/RHC services or be paid the PPS rate. The FQHC is rendering provider and is designated by Provider Type, not place of service. |
| **47** | **United** | 6/26/2014 | Are there any circumstances where a provider should receive a payment in addition to the PPS rate? | No, FQHC RHC payment at PPS is payment in full/PPS rate is all inclusive. |
| **48** | **United** | 6/26/2014 | If an E&M service meets a 25-modifier criteria, the provider gets a PPS rate for that day as well, correct? | See definition of a visit on # 33 and #44 for E&M clarification. Definition of appropriate modifiers for use with the T1015 code is in progress. |
| **49** | **United** | 6/26/2014 | If the E&M service is billed incorrectly, but all the other lines on the claim are billed correctly; assume the E&M line gets denied and no PPS rate is apply until the provider files a corrected claim, correct? If we pay on the E&M line and do not pay the additional covered lines on the rest of the claim; what reason codes should be used on the non-paid lines (45?)? | Correct. Per workgroup discussion of appropriate reason codes it was decided for consistency to use standard coding of "Including in visit rate. Disallowance/Cutback". See #44 for E&M clarification. |
| **50** | **United** | 6/26/2014 | Today we have a delegated vendor for Lab Services. If a member goes into an FQHC/RHC and only gets lab services, we would deny the claim and no PPS rate payment is made. Is that still allowed? | A lab visit provided by the FQHC would be incident to an FQHC/RHC visit therefor there would be no separate payment for the lab service. |
| **51** | **United** | 6/26/2014 | Confirming injections, even high-dollar injections, are included in the PPS rate. | PPS rate covers all services as incidental to. |
| **52** | **United** | 6/26/2014 | We currently have a policy that says certain injectable need to be billed thru pharmacy/NCPDP; therefore injectable CMS1500 claims would be denied for that reason; so would a PPS rate still apply? | To the extent that it is not billed as a pharmacy claim, then yes. If billed as a pharmacy claim would fall under 340B payment rates. |
| **53** | **United** | 6/26/2014 | If we deny the pharmacy/injection and an E&M code was also billed, assume the PPS rate still gets paid on the E&M line, correct? | Yes the PPS rate is all inclusive of items billed on the applicable 1500 or ADA claim form. |
| **54** | **United** | 6/26/2014 | If a pharmacy claim (NCPDP) and dental claim (ADA) are billed on the same day; this doesn’t affect any part of the program; since this is strictly based on CMS1500 forms, correct? | Correct for Pharmacy, dental visit billing for FQHC/RHC's will be on an ADA form as appropriate. Please clarify the question. |
| **55** | **United** | 6/26/2014 | Today when a dental svc requires anesthesia; an ADA claim is submitted for the dentist, but an anesthesia claim is billed on a CMS1500; does a PPS rate apply to the anesthesia claim? | Yes. |
| **56** | **United** | 6/26/2014 | If a member’s covered services/therapy benefit is reached, there is no PPS rate paid, correct? Same question, but assume the member is a QMB member, does the same rule apply? | Benefit limits apply as defined, including appropriate exceptions, thus unless meeting a defined exception the payment is denied. |
| **57** | **United** | 6/26/2014 | Confirming that Global OB billing will be paid the FQHC PPS rate, correct? | No, FQHC/RHC's will be paid the all-inclusive PPS rate for qualifying visits. The PPS rate is inadequate reimbursement for the global OB package; in addition, the inpatient portion of the global OB is not eligible for the PPS rate. For this reason, FQHC/RHC's should bill the antepartum and postpartum services using the appropriate CPT codes, and the inpatient delivery will have to be billed separately. |
| **58** | **United** | 6/26/2014 | If only post-partum services are done by the FQHC, they are still due the PPS rate, correct? | Correct, this should be billed using the CPT code for postpartum only. |
| **59** | **United** | 6/26/2014 | If the provider does antepartum care only (4-6 visits) per the CPT definition, they are eligible for 1 FQHC visit rate, correct?  Follow-up question – How should antepartum services be billed? | No. Each antepartum visit constitutes an FQHC visit, and should be billed using a T1015 codes and an appropriate E/M code rather than the Global CPT codes. Billing will result in each antepartum visit with a T1015 under the FQHC/RHC and a delivery only procedure under the practitioner.  AHCCCS will follow-up with appropriate clinical quality management staff on this question to ensure policy requirements are met. |
| **60** | **United** | 6/26/2014 | Today, for quality measurements, if a global OB procedure is billed and the antepartum lines are missing on the claim, or in claim history, we denied the global payment (PPS rate). When the provider re-bills the claim with the antepartum line, we pay the global OB payment. Can we still use this methodology under the per-visit program? | No, please see #57 above. |
| **61** | **United** | 6/26/2014 | What are the billing guidelines for those RHCs that will also have a provider type 02 with OFPS rates and can bill revenue code 510-Clinic visits. How do we educate them on when to use the new RHC provider type & NPI vs. the RHC provider type 02 & NPI? | RHC services should be billed only under the RHC provider. Other hospital clinics may bill under the hospital but not RHCs. |
| **62** | **United** | 6/26/2014 | If a UB claim and CMS1500 claim is billed on the same day; and we pay the per visit rate on the CMS1500 claim; assume the UB claim still get paid according to the AHCCCS hospital rate or OPFS rate, correct? | See response to #61. |
| **63** | **United** | 6/26/2014 | If an office visit and an anesthesia time based code are billed, should we pay one PPS rate? | Yes. See definition of a visit on # 33. |
| **64** | **Care1st** | 6/26/2014 | Payment when office visit is not performed. If the office only performs an in office procedure, i.e. no office visit is billed, does the visit rate apply? If the office only does a lab draw, flu shot, or other vaccine administration and no office visit does the visit rate apply? | No, this would indicate services that are incident to a prior visit. |
| **65** | **Care1st** | 6/26/2014 | FQHC Look alikes. Will the visit rate apply to FQHC look alikes, i.e. MIHS? | Yes |
| **66** | **Care1st** | 6/26/2014 | Total OB packages. How are these paid?  Is the visit rate paid for each office visit and the delivery paid separately?  If so, is the per visit rate paid for prenatal office visits billed under the FQHC NPI and the delivery billed and reimbursed under the actual OB’s NPI? | Correct, refer to #57. |
| **67** | **Care1st** | 6/26/2014 | When a procedure is performed, i.e. crown, and a visit/exam is not completed does the visit rate apply? | Yes. A face-to-face encounter for the purpose of performing the dental procedure is an FQHC visit. |
| **68** | **Care1st** | 6/26/2014 | Are the FQHCs expected to have a different NPI for each location or do they only need one for the entire practice?  Also, will AHCCCS allow one FQHC to have a separate NPI for each facility while another FQHC only has one NPI for all facilities? | Yes. All are required to have to have a unique NPI and AHCCCS provider ID for each location. |
| **69** | **Care1st** | 6/26/2014 | If we are secondary to another payer, are we still allowed to pay the lesser of or does the visit rate apply? | Lesser of the logic applies but compared to MCO payment at the PPS rate. |
| **70** | **Care1st** | 6/26/2014 | When will the visit rates by FQHC be available to the health plans for the October 1, 2014 plan year?  For services we have capitated for our entire AHCCCS population through another provider such as dental we will need to do utilization studies to see how this will impact our capitation and we need the new visit rates to calculate the impact. | Rates have been released, and will be incorporated into AHCCCS production region Provider tables concurrent with the 4/1/2015 implementation. Rates will be loaded into the AHCCCS test region Provider tables as soon as possible. |
| **71** | **Care1st** | 6/26/2014 | All inclusive visit rate? We want to confirm we are expected to pay the FQHC an all-inclusive visit rate.  No other services are to be paid separately, outside of the per visit rate – correct? | See definition of a visit on # 33. |
| **72** | **Care1st** | 6/26/2014 | Primary Care vs Dental vs OB. Is this only for primary care services?  Most, if not all of the FQHC’s have dental and OB and we don’t understand how this new process works as far as the services billed by these providers? | See definition of a visit on # 33 and see #32 for information on the T1015 procedure codes that identify a visit for 1500 and ADA claiming. This is not only primary care; FQHC/RHC's are entitled to receive the PPS rate for all ambulatory services covered under the Medicaid State Plan. |
| **73** | **Care1st** | 6/26/2014 | Midlevel Reimbursement: Are we correct in assuming the mid-level providers will be paid the same visit rate?  Today we pay them at a reduced rate. | Refer to #43. |
| **74** | **Care1st** | 6/26/2014 | FQHC Reconciliations: Currently, when AHCCCS completes the recons with the FQHCs, does AHCCCS look at all of the dollars paid by the plan to the FQHC or only dollars for certain services? | MCOs are not involved with FQHC/RHC reconciliation process. |
| **75** | **MIHS** | 7/23/2014 | We were informed by AACHC that the FQHC/RHC MCO Payment Process has been delayed for implementation until 4/1/2015. Does this also postpone the 10/1/14 deadline that all FQHCs/RHCs must: a. Acquire and use separate NPIs and AHCCCS numbers for each billing location, and b. Bill all FQHC/RHC services on Form-1500 with the FQHC's/RHCs site-specific NPI as the rendering provider using the FQHC Provider Type. | Correct. Yes, although timely registrations are desired, encouraged and are at this time completed or in final process for all impacted providers. Just a reminder effective date has been revised to 4/1/2015. |
| **76** | **United** | 9/3/2014 | #9 on the Q&A log mentioned the use of ADA forms for dental services.  Our dental department is inquiring what the “state defined field” will be on the ADA form for the provider NPI who provided the dental service. | AHCCCS has outlined and distributed billing requirement for providers to utilize an identified field for the reporting of the "participating" provider on both the 1500 and ADA claim forms/file formats. |
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| **77** | **United** | 10/6/2014 | For dual, cost shared claims, who will bill as servicing provider on the primary claim?  Will it be the new FQHC facility, i.e. the same NPI that is supposed to be billed on a Medicaid claim? | AHCCCS FQHC/RHC billing policies will require that secondary billing be reported on a HCFA 1500 or ADA form with the appropriate Medicaid NPI. |
| **78** | **United** | 10/6/2014 | Will each FQHC location get its own new NPI?   I.e. for a given TIN and new AHCCCS provider id corresponding to their new record and provider type, could we end up with multiple NPIs that are address based?  Could we have a situation that one FQHC might have 1 new NPI for all locations whereas another would have 1 NPI per location? | To the extent each location is separately registered with AHCCCS each will have a unique NPI. |
| **79** | **United** | 10/6/2014 | When will AHCCCS be able to post the updated Q&A doc to the technical workgroups page?  All of our partners are asking us. | Will be posted following this Workgroup Meeting, on the Technical Workgroup webpage. |
| **80** | **The University of Arizona Health Plans** | 11/10/2014 | MIHS would like clarification regarding how AHCCCS plans will handle their secondary claims when CMS is primary.   CMS does not consider MIHS an FQHC therefore MIHS will bill CMS on a UB for the facility portion of the visit and on a 1500 for the professional portion.  MIHS will bill AHCCCS providers on a 1500 for the entire visit.   MIHS will no longer have the capability to bill their secondary claims electronically as they will provide the plans both the UB and 1500 EOB’s.  MIHS would like to ensure all plans will apply the payments reflected on the EOB’s consistently. | Refer to #77. |
| **81** | **The University of Arizona Health Plans** | 11/10/2014 | MIHS would like clarification regarding how plans will process OB claims for antepartum visits which occur prior to January 1st and were previously included in a TOB package. | Note effective date is now April 1st. Provider is seeking consistent handling across contractors. Workgroup agreed upon the option to “break” the Total OB Package (TOB) like you would do when member moves from one provider to another (pay services prior to 4/1 at FFS to provider, pay visits after 4/1 to FQHC).  Note that this same type of global services consideration and handling must be applied to other types of services typically reimbursed globally, i.e. surgery including pre and post op visits. |
| **82** | **The University of Arizona Health Plans** | 11/10/2014 | MIHS will continue to bill 99211 for nurse only visits.  These may be billed on separate claims.  I advised MIHS that these would be considered part of the Global visit.  MIHS would like to see these as approved for a 0 payment and not as denied services. | Agreed, these claims would not reflect a T1015 code but could be billed under the FQHC/RHC. |
| **83** | **United Healthcare** | 11/10/2014 | Would you confirm there have been no decisions made to edit the notes field?  It was previously reported there are no Encounter edits planned. Is this still the case? | Correct, refer to #26. |
| **84** | **United Healthcare** | 11/10/2014 | Our Dental Plan would like to recode dental claims to use code D9999 as the grouping code?  Our dental claims system is currently set to use D9999 as the regrouping code for other national markets, and it would be helpful if this were consistent for AZ. | Refer to #32 for final coding decisions including dental visits. Discussion re-opened in 2/4 meeting to be finalized by 2/13. |
| **85** | **CPSA** | 1/20/2015 | When will we receive additional details on the services that would be bundled into the G codes (or is it any/all services provided on that same date at the same location)? | Refer to #’s 32 and 44. |
| **86** | **CPSA** | 1/20/2015 | Is the format of how to report the participating providers finalized?  How would we report more than 2 providers and/or information that may exceed the field length, do we report extra segments to handle this? | Refer to #76. Instructions include how to report up to 2 participating providers per claim and repeat the associated loop as needed for additional occurrences. |
| **87** | **CPSA** | 1/20/2015 | Can the FQHC be paid for two G codes in one day if the specialties are different or are they simply reported together on the claim and they get paid once regardless of specialty? | See definition of a visit on # 33. |
| **88** | **United** | 1/22/2015 | If the provider bills less than the PPS rate can we still allow payment at the lesser of billed charges or the PPS rate or does the visit rate apply? | Billed Charge Lesser of the logic applies |
| **89** | **NARBHA** | 1/22/2015 | Is there a restriction that the T1015 FQHC/RHC code be billed on the first line of the claim? | There is no restriction on this from the AHCCCS billing perspective. |
| **90** | **United** | T0105 code use feedback | T1015 is currently a noncovered code | Under this proposal AHCCCS would be changing this code to covered, but limiting its use the 3 MSIC’s (as a provider specific code inclusion) and the FQHC/RHC Provider types. |
| **91** | **United** | T0105 code use feedback | Will there be additional encounter edits or revisions to edits to allow both T1015 for MSIC clinics and FQHC/RHC clinics. AHCCCS does not anticipate the need to add new edits and will utilize existing edits under this proposal. | AHCCCS does not anticipate the need to add new edits and will utilize existing edits under this proposal. |
| **92** | **United** | T0105 code use feedback | T1015 is not reimbursable by third party payers; therefore they are special COB requirements to pay as primary for MSICs. Additional instructions will need to be written to if FQHC/RHC are allowed. | May need further discussion, and will be covered as a component of the billing instructions to the FQHC/RHC’s. FQHC/RHC’s specifically requested a unique code. Related questions in the MCO matrix have also been updated to reflect the new billing instructions that will be provided. FQHC/RHC could include both the G and T1015 codes in their billing; Medicare and possibly OTI would pay under the G code and Medicaid would pay under the T code. |
| **93** | **United** | T0105 code use feedback | T1015 is not reimbursable by Medicare; Medicaid will pay 100% as primary for members with other insurance. . – | Need further discussion, and will be covered as a component of the billing instructions to the FQHC/RHC’s. FQHC/RHC’s specifically requested a unique code. Related questions in the MCO matrix have also been updated to reflect the new billing instructions that will be provided.See #92. |
| **94** | **United** | 2/4/2015 | If AHCCCS will have new Medicare PPS proc codes listed as noncovered, do any QMB member exceptions apply?  Question applies to:  QMB duals, QMB non-duals in network, and QMB non-duals out of network. | No, refer to #93. |
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