FQHC/RHC QUESTIONS

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 and will share with BHS this concern.
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.
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 will develop and provide examples.
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.

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Question Number	Question submitted by	Date submitted	Question	Response
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 using their NPI for the FQHC or RHC. There are no specific billing changes at this time and FQHC/RHC providers are expected to bill with standard coding for all services.
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?	This is an open issue that AHCCCS is actively reviewing for a timely resolution. At this time, AHCCCS is considering a requirement that FQHC/RHC providers utilize an identified field to report the rendering practitioner. More information will be coming shortly.
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.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
15	**PHP**	6/26/2014	How and when these rates will be provided as well as what constitutes a 'unique' visit?	The intent is to get real rates within 30 days of implementation but a limited number will be provided in the test region by September 1, 2014. 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. You are correct, the NPI in the rendering provider field is the FQHC or RHC. It is the diagnosis codes that define the discipline.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
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 meeting is scheduled for August 13, 2014.
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 recently implemented an FQHC/RHC webpage - 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, this information will also be posted to the AHCCCS FQHC/RHC webpage.
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.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
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. We will be issuing a Provider Profile for the new FQHC and RHC Provider Types.
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)	Follow current COB policies and guidelines.
30	**United**	6/26/2014	Are there any special requirements for Dual-eligible members or differences in between Medicare and AHCCCS on PPS?	MCOs should continue to follow AHCCCS Medicare cost sharing policy.
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)	MCOs should continue to follow AHCCCS Medicare cost sharing policy.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
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)	No these codes will remain non-covered for AHCCCS; however AHCCCS will recognize and allow these code for Medicare primary COB claims and encounters consistent with current coverage practices.
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 FQHC/RHC provider ID and NPI.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
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.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
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?	Nothing, if no payable code is billed.
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?	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.
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.
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 (452)?	Correct. Further workgroup discussion of appropriate reason codes will occur.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
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 E&M visit therefor there would be no separate visit to a lab.
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 1500 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.
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 and all billing is on a 1500 form for the FQHC and RHC Provider Types.
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?	TBD ***Research in progress
58	**United**	6/26/2014	If only post-partum services are done by the FQHC, they are still due the PPS rate, correct?	TBD ***Research in progress
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?	TBD ***Research in progress

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
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?	TBD ***Research in progress
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 a 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?	TBD ***Research in progress
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?	No. This would indicate services that are incident to a prior visit.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
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.	The intent is to get real rates within 30 days of implementation but a limited number will be provided in the test region by September 1, 2014.
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. Open issue - Research in progress related to OB.
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.

FQHC/RHC QUESTIONS

Question Number	Question submitted by	Date submitted	Question	Response
75	**MIHS**	7/23/2014	We were informed by AACHC that the FQHC/RHC MCO Payment Process has been delayed for implementation until 1/1/2015. 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 and encouraged.