FQHC Technical Workgroup
October 15, 2014; 1:00 PM-2:30 PM
AHCCCS, 701 E Jefferson, Phoenix - Gold Salmon Rooms, 3rd Floor

Attendees (Based upon sign-in Sheets)

AHCCCS
Lori Petre, Shelli Silver, Victoria Burns, Kim Bodary, Dave Mollenhauer, Gina Aker, Arturo Cruz

Care1st
David Scheer, Tim Tejada, Susan Cordier

CPSA
Yolanda Thompson, Derell Ware, Naomi Martinez, Eunice Rhodes

DCS
D. Gardner

Health Net
Bruce James, Kathleen Semien, Kimberly Tripp, Bob Detken

Health Choice
Rob Neely

HCA
Mia Villa, Sarah Sautter, Veronica Joramillo

Mercy Care
David Vargas

Mercy Maricopa
Vickie Payan

UAHP
Maria Sanchez, D. Hardesty, Dennis Thompson, Dan Parker

UHC
Deb Alix

UHCCP
Jeff Greenspan, Denise Hardesty

PHP
Mike Flynn

GoTo Participants:, Jeffrey Schleidt, Tia Martinez, Samit P Thakur, Laurie K Schacht, Kayla Caisse, Helen Bronski, Renee Garcia, Mary Kaehler, Susie Knobbe, Victoria Rita D Perez, Christine Davis, Gale Leair-Kaiser, Bill, Tricia, Cathy Karson, Kristin, Aaron Theby, Bobbie Wilkes, Pamela Choate.

Welcome

Lori welcomed everyone and provided key updates related to the project since out last meeting.

Everything including handouts and the meeting minutes are posted to the website. If you see anything that isn't correct, please let us know as we want a complete and accurate record.

Lori confirmed with Victoria that the letters were sent to the FQHCs and RHCs and are posted to the website.

Two plans have sent examples already in which Lori will share with Becky Fields who is completing our billing instructions. These examples are very helpful as we don't want to make the assumption that the FQHCs are billing everyone the same way. Please continue to send the examples if you have them. We will also plan to review some or all of these in our next Workgroup meeting.

Lori did follow up on a previous action item and the date change with Tricia but she has not heard back from her yet.

ACTION ITEM: Lori to follow up with Tricia on date change.

Another action item from the last meeting was to update the answer to question number 46. After some discussion, the answer is based on the individual physician.

Victoria said we are adopting the G Codes that Medicare created for the FQHC visits. The first thing we noticed about it looking at the way it is set up in our system by our coding (coverage) group assigning places of service that would be appropriate for various procedure codes. They are taking this from national guidance. One of the few places of service that is attached to the G-Code is 22, outpatient hospitals. Our first assumption is that is contemplated by these codes. We wouldn't put outpatient hospitals on the automatic no list but we will clarify this with the coding group and see where they came up with that information. Looking at question 46 and 21, 22, and 24 logically if we were to allow it in an outpatient hospital AFC would also be ok. Question 46 is specific to the physician. Looking at the place of service codes and some are showing up in the utilization data for these. The ones we have come up with that we think would be a definite no would be place of service 01-pharmacy, POS 21– inpatient hospital, 23-emergency room, and 51- inpatient psychiatric facility, 61 – comprehensive inpatient rehab facility, and POS 81 – independent laboratory. What we are looking at with these is places of service where a visit can occur and a laboratory wouldn't qualify. Victoria is also suggesting we add to the list 99 – other unlisted facility.

Question: Shelli asked if this list is just a tentative list, a work in progress, or final list.

Answer: Victoria answered these are definite no's but we discussed before doing a yes, no and maybe list but the yes and maybe list are less clear. These are obviously not places where an

FQHC visit would be occurring under normal circumstances. We would be ok denying an FQHC PPS rate which is the place of service.

ACTION ITEM: Lori will see the question into the matrix and make sure the answers are very clear with what the question was.

Victoria said an FQHC service can definitely be performed in a patient's home. In a home under some circumstances, a RN could be the provider. Home is definitely ok for an FQHC. Different other facilities would be ok also. An example would be a nursing facility. We are very open to input from everyone.

Question: Will you be adding additional places of service to the G Codes?

Answer: Victoria said they will be discussing this with the coding group to make sure that everything which would be appropriate for an FQHC service as we understand it won't be bouncing out.

Lori mentioned she made a few other updates to the matrix. Shelli said we have been working on trying to finalize the matrix so we can get it posted as we know the FQHCs are asking the same questions. We also posted 4 or 5 most asked questions. This is all on the FQHC webpage located at: http://www.azahcccs.gov/commercial/EDIresources/EDITechnicalWorkgroups.aspx.

The letters that went to the FQHCs and the RHCs are also posted on the website.

As of today, there are only 2 providers who have not yet responded. Seventeen are complete and 7 are in process. They have until November 1st and will be shut out as January 1st if they don't respond. AHCCCS will be doing everything they can though to make sure they all get re-registered.

FQHC/RHC Q&A's Related to January 1, 2015 Changes as Tracked in the AHCCCS Matrix

- Question #7: Answer was updated to show we are working on a proposal.
- Question #10: Becky Fields from AHCCCS-DFSM is working on the billing requirements. Lori is waiting for a draft from Becky to see where the holes are.

ACTION ITEM: Lori will follow up with Becky on the draft.

- Question #18: Lori updated to say we'll continue to have workgroups as needed.
- Question #22: Clarified the answer.
- Question #28: We added a clarification we are working on the build so codes get updated with the places of service. Test rates have gone out so please make sure you remember these are test rates and not the real rates.

Question: If you are getting individual NPI numbers for each site you will actually end up getting the actual individual AHCCCS ID number because these are provider specific rates each provider will have rates.

Answer: There will be a separate AHCCCS registration number for each site. So there will be a separate fee schedule for each AHCCCS registration number. Nothing has changed on the way we set the rates. You need a provider ID with a unique NPI. We don't allow the same NPI to live under two provider IDs.

- Question #32: This was updated to reflect the D codes. Lori said she would caution using a G code on an ADA form. Stick with the D codes on an ADA.
- Question #49: This was clarified. We are open to conversation on the reason codes. These are truly no pays and not denials.

ACTION ITEM: Lori will make sure the examples show services on the same line.

- Question #57: Rates will be in range of $150-$250 per visit. In the global, rates will be closer to $1500. Part of the global OB package is not part of an FQHC package.

ACTION ITEM: Get this question and answer posted to the website.

- Question #70: Lori does have the test rates and will send them out. Shelli said we can't get real rates out yet as we are mandated to inflate the PPS rates and Victoria and her staff has to wait until the appropriate inflation factor (one stated in state plan) is released by the federal government. We may have to change our state plan going forward because of course we would have the rates final for you and us every September 1st. So if we are in this waiting game for the inflationary factor.
- Question #72: Updated
- Question #76: Updated to reflect final decision.
- Question #77 (New): Shelli said you are having them reform to the Medicaid billing requirements for the Medicare primary. Shelli said we are required to pay as a secondary regardless whatever we dream of as a reimbursement methodology or a billing requirement or anything else. We could pay in rubles but we still have to cost share. It doesn't relieve us of our cost sharing responsibilities. Shelli thinks the answer may be if you don't have a contract for them to follow the AHCCCS method then you will have to deny and require them to re-bill in a manner that allows you to pay. Maybe AHCCCS should encourage FQHCs to contract with their Medicaid payer under the Medicaid billing methodology for their Medicare primary.

Question: Shelli asked the group if they had other examples of where the Medicare and Medicaid billing rules are different. When you pay a secondary on those, do you deny the initial claim and require them to rebill? Do you do the denial of the first way and then require them to rebill in a manner in which you can pay?

Answer: Someone answered home health is a good example.

ACTION ITEM: If anyone finds out any more about this and can share with the group, please feel free to bring it back to the next meeting.

- Question #78 is new and updated.
- Question #79 is new and updated.

Lori pulled out everyone's responses to our request for your timelines on the FQHC/RHCs as well as the follow-up email that was sent asking what your burning questions or issues are. Lori reviewed the responses. She asked for clarification on PHPs encounter question which was given.

There was a question on the use of modifiers and edits. We started talking about the 25 modifier last time and we wanted the billing instructions to reflect utilizing those codes. This was modifiers 25 and 59. EP needs to be added to performance for utilization.

There was a question on a visit where 2 different incidents occur. Victoria said it should be treated as 2 distinct visits. If you were doing that today, whether or not you are and FQHC, wouldn't you bill the 2 distinct E&M codes, and one would have a modifier saying please don't deny this as it's a distinct service. There could be 2 G Codes referencing two different diagnoses in same or separate claims. You would want to use the 25 modifier to distinguish that as a separate visit. Lori will try to put some of these in the examples.

Please check your duplicate edits as in some systems, some systems review the 25 but some recognize them as distinct visits.

From the descriptions of the G Codes, the well visit would be used as the EPSDT visit that would be distinct from the other services.

Shelli said if we only got the G codes and not the E&M codes you're going to have a problem with your performance measures for adolescents versus children.

Shelli asked if your systems can be programmed to say I won't pay a visit code on the G code unless something else is present?

Lori mentioned we are waiting for the billing draft from Becky which needs to be sent to the FQHCs and RHCs.

Question: So G codes and E&M codes have to be on the same claim or separate claims?

Answer: To the extent you let them bill separate claims now. If you are not applying CCI edits across the claim, you're not applying CCI edits right. It's the same day of service and don not have to be on the same claim.

Question: The dental varnish code for a well visit and its part of the pay for visit, that it isn't an expectation they will pay additional?

Answer: Victoria isn't sure what their expectation is but they aren't going to get paid anything additionally. Shelli thought money was added to the cap rate for dental varnish. A primary care provider gets an additional payment. Lori said he wants it on the matrix so they see that and thinks that it applies to them under the definition of a visit.

Question: If a physician ends up billing an FQHC service individually and puts the pay for visit code on there. The issue is we are going to deny the whole claim.

Answer: Shelli said if it's the provider ID of an individual practitioner with a G code expecting a visit payment. Shellie sked if you would deny or pay an individual provider a fee for service rate and Lori said to deny a fee for service rate. If a doctor is not working for an FQHC and billing individually, he cannot use a G code.

Victoria said they are updating the Q&A's on the website and will get those reposted soon.

ACTION ITEM: Follow-up on how the participating provider information is going to come back to you on encounters.

So far we defined how the participating provider information will come in and we wanted to make sure we were all in agreement. What screen will it go on, where will you be able to look at it, how it will be incorporated in back end reporting, etc. is the next step. Lori is guessing it will have to go on the 277 supplemental rather than the 277 unsolicited.

FQHC/RHC Participating Provider Reporting – Draft for Comments/questions: We will extract this from this document and make it part of the billing rules. We will get you something out that you can have in the meantime.

AHCCCS FQHC/RHC Encounters Transaction Testing Overview: Just the basics of the overviews. Lori is working on doing about a dozen examples. We hope to open the testing window on Nov 1st. Dave & Lori are still working with IT staff on dates.

Test Rates: This is a list of the **test** rates that will be loaded into the system. Hopefully by next week provider file you will have the profile for the provider and it will be complete as well as these rates on providers.

Examples: Lori showed some examples that have come in and what has been helpful.

Next Workgroup Session

Next meeting scheduling is TBD and notification will be coming from AHCCCS.