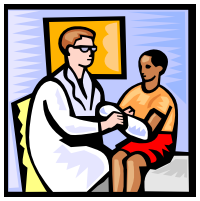

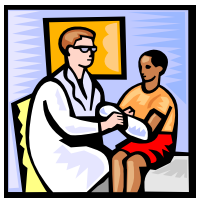

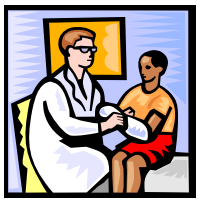

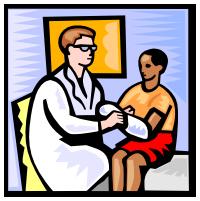

Rural Health Clinic and Federally Qualified Health Centers

Medicaid and Other Medical Assistance Programs

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

August 2015

This publication supersedes all previous Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) handbooks. Published by the Montana Department of Public Health and Human Services, May 2006.

Updated June 2011, March 2013, June 2013, October 2013, March 2015, and August 2015.

My NPI/API:

Table of Contents

Key Contacts and Websites

See the Contact Us link in the menu on the Provider Information website, http://medicaidprovider.mt.gov, for a list of key contacts and websites.

Introduction

Thank you for your willingness to serve members of the Montana Healthcare Programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Materials have been consolidated whenever possible. Specific mention will be made when information is for both RHCs and FQHCs (B), RHCs only (R), and FQHCs only (F). In this manual, the term clinic refers to both RHCs and FQHCs.

Additional information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both manuals.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of contacts on the Contact Us page of the Provider Information website. We have also included a space on the inside front cover to record your NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

Changes to manuals are provided through provider notices and replacement pages. When replacing a page in a paper manual, file the old pages and provider notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails**. Links to rules are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office. See the Contact Us link in the left menu on the Provider Information website.

Providers are responsible for knowing and following current Medicaid laws and regulations.

In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to RHCs and FQHCs:

- Code of Federal Regulations (CFR)
  - 42 CFR 405.2400–42 CFR 405.2472
- Montana Code Annotated (MCA)
  - MCA 53-2-201, 53-6-101, 53-6-111, and 53-6-113
- Administrative Rules of Montana (ARM)
  - ARM 37.86.4401–37.86.4420

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims it cannot detect. For this reason, payment of a claim does not mean the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed that may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). See the Contact Us link in the left menu on the Provider Information website. Medicaid manuals and replacement pages, provider notices, fee schedules, and more are available on your provider type page.

Covered Services

General Coverage Principles

Medicaid covers almost all services provided in an RHC or FQHC when they are medically necessary, including preventive primary services in FQHCs. This chapter provides covered services information that applies specifically to RHCs and FQHCs. Like all healthcare services received by Medicaid members, these services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

As a condition of participation in Medicaid, a clinic must meet all requirements generally applicable to Medicaid providers. The health professionals must meet the same requirements as if enrolled themselves, including licensure, certification, or registration for his/her provider type. Each clinic provider also must maintain a current Medicaid provider enrollment.

Clinics have the same limits on amount, scope, and duration of services covered by the Medicaid program such as medical necessity requirements and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements and restrictions.

Service Settings

Clinic services are covered when provided in outpatient settings including the clinic, other medical facility (including a dental office) or a patient's place of residence. A patient's place of residence may be a nursing facility or other institution used as the patient's home. Clinic services are covered off-site as long as the service is normally furnished within the scope of the clinic's professional services. Services provided off-site are part of the clinic benefit if the provider has an agreement with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic doesn't compensate the provider for services provided off-site, the clinic may not bill Medicaid for those services.

FQHCs and RHCs must not bill in the hospital setting (ARM 37.86.4406(3)(4).

FQHC and RHC providers who perform services in a hospital setting must bill the service on a CMS-1500 form using their own provider number.

Pre- and post-visits at the clinic are billed by the clinic on a UB-04 as a core service.

Satellite Clinics

If clinic services are furnished at permanent units in more than one location, each unit is independently considered for approval as a clinic, unless prior approval was granted by CMS to operate both locations under one provider number. To be considered a satellite clinic, both sites must share medical staff,

office staff, and/or administrative staff. DPHHS must be notified in writing of approval by CMS to operate under one provider number prior to billing for services at the satellite clinic.

Clinic Covered Core Services

The following are covered core services in RHCs (R), FQHCs (F), or both (B) and may be billed as a visit when there is a face-to-face encounter with the patient:

- B – Physician services
- B – Nurse practitioner, nurse specialist, certified nurse midwife or physician's assistant services
- B – Clinical psychologist, clinical social worker and licensed professional counselor services
- B – Dentist services
- R – Visiting nurse; see Coverage of Specific Services later in this chapter
- F – Preventive primary services; does not include eyeglasses or hearing aids, but does include:
  - Perinatal care for high-risk patients
  - Tuberculosis testing for high-risk patients
  - Risk assessment and initial counseling regarding risks
  - Preventive dental

Services and supplies furnished as incidental to the above providers (by non-core providers such as lab techs, radiologists, LPNs, etc.) are included in the provider's rate but are not billable as a stand-alone visit even if the service is performed on a separate day from the core visit. They include:

- B – Furnished as an incidental, although integral, part of the physician's or mid-level practitioner's professional service (i.e., influenza vaccine/ administration)
- B – Service commonly rendered without charge or included in the clinic's claim
- B – Service that is commonly furnished in a physician's office or a clinic
- B – Basic lab services essential to the immediate diagnosis and treatment of the patient
- B – Furnished under the direct, personal supervision of a physician, mid-level practitioner, psychologist, or social worker.
- B – In the case of a service, furnished by a member of the clinic's healthcare staff who is an employee of the clinic
- B – Drugs and biologicals that cannot be self-administered
- B – Radiology, including ultrasound
- B – Pharmacist-only visits of any kind
- B – Outreach
- B – Case management
- B – Transportation

Vaccines and the administration of vaccines are not covered services in an RHC or FQHC setting and are not separately billable, except services provided to children enrolled in HMK. If vaccines are administered to an HMK-enrolled child without a physician or mid-level visit, providers may also bill for an administration fee. Refer to page 2.6 of this manual for additional information regarding HMK vaccination billing.

These services are considered as part of the covered core services offered by RHCs and FQHCs and are included within the facility's rate per visit when there is a face-to-face encounter with the member.

Regarding HMK qualified members, providers may bill Blue Cross and Blue Shield of Montana (BCBSMT) for vaccines. If vaccines are administered without a physician or mid-level visit, providers may also bill BCBSMT an administration fee for each immunization. Refer to page 2.6 of this manual for additional information regarding HMK qualified members and vaccines.

Dental hygienist services may be billed by clinics as a stand-alone visit provided they are performed by a licensed dental hygienist (under the direct personal supervision of a licensed dentist).

Ambulatory Services

Services other than core services that would be covered under the Montana Medicaid program if provided by an individual or entity other than a clinic in accordance with Medicaid requirements. ***These services are subject to any applicable limitations on the amount, scope, or duration of services covered by the Medicaid program (e.g., limits on hours for therapy services, medical necessity criteria).*** Many of these services also require Passport referral, and some emergency dental services for adults may require Department authorization. Please check the appropriate Medicaid manual for specific information concerning these services.

- B – Respiratory therapy and inhalation therapy services
- B – Physical therapy services
- B – Occupational therapy services
- B – Audiology services
- B – Dental services
- B – Mental health services

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (ARM 37.86.2201–2235)

The Well-Child EPSDT program covers all medically-necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages.

Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School-based services

All prior authorization and Passport approval requirements must be followed. See the Prior Authorization chapter in this manual and the *Passport to Health* manual, available on the Provider Information website.

For more information about the recommended well-child screen and other components of EPSDT, see the *General Information for Providers* manual.

Non-Covered Services (ARM 37.85.207)

The following is a list of services not covered by Medicaid. Some of these services may be covered under the EPSDT program for children age 20 and younger based on medical necessity or for individuals covered under the Qualified Medicare Beneficiary (QMB) program. (See the Member Eligibility chapter in the *General Information for Providers* manual.)

- Acupuncture
- Allergen immunotherapy services
- Chiropractic services
- Delivery services not provided in a licensed healthcare facility unless as an emergency service
- Dietician/nutritional services
- Dietary supplements
- Exercise programs and programs that are primarily educational, such as:
  - Cardiac rehabilitation exercise programs
  - Pulmonary rehabilitation programs
  - Nutritional programs
  - Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
- Homemaker services
- Infertility treatment
- Massage services
- Naturopath services
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- Services considered experimental or investigational
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid

Use fee schedules to verify coverage for specific services.

member is financially responsible for these services and the Department recommends the member agree in writing before the services are provided. See the Billing Procedures chapter in the *General Information for Providers* manual.

- Vaccines and the administration of vaccines
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

Coverage of Specific Services

The following are coverage rules specific for RHC and FQHC services.

Visiting Nurses (RHC Services Only)

Part-time or intermittent nursing care and related medical services other than drugs and biologicals may be provided to a homebound individual (see definition below) by a clinic:

- Only in geographic areas designated by the Secretary of the United States Department of Health and Human Services as having a shortage of home health agencies and services;
- **When services are rendered to a homebound patient only. A homebound individual is a person who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. For this purpose, place of residence does not include a hospital or long-term care facility.**
- When a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed or compensated by the clinic furnishes services.
- Under a written plan of treatment which is either established and periodically reviewed (at least every 60 days) by a physician or established by a nurse practitioner or physician assistant and periodically reviewed and approved by a supervising physician (at least every 60 days).

Laboratory Services

Clinics must send a copy of their Clinical Laboratory Improvement Act (CLIA) registration number to Xerox. These numbers are assigned by CMS.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

MHSP services are allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the mental health manual available on the Provider Information website.

Healthy Montana Kids (HMK)

The information in this chapter applies to HMK for RHC and FQHC clinic services.

Providers may bill HMK revenue codes 512, 521, 636, 771, and 900. Providers billing for HMK dental services must be enrolled as HMK dental providers.

Since HMK-enrolled children are not entitled to the Vaccines for Children (VFC) program, providers may bill Montana Medicaid for vaccines using revenue code 636 and the vaccine procedure code. If a child receives a physician or mid-level visit, vaccines will be paid and administration fees will bundle with the visit fee and pay at zero. If vaccines are administered without a physician or mid-level visit, providers may also bill for vaccine administration fees using revenue code 771 and vaccine administration procedure codes. An immunization-only visit does not qualify for a visit fee.

For more information, contact Blue Cross and Blue Shield of Montana at 1-800-447-7828. Additional information is available on the HMK website.

Prior Authorization

In addition to the information below, see the Prior Authorization Information link on the Provider Information website and the *General Information for Providers* manual.

Passport information is found in the *Passport to Health* manual, available on the provider type page.

Prior Authorization Requirements for RHCs/FQHCs

RHC and FQHC services do not require prior authorization unless the procedure code requires it. If you are making a referral, remember that some services require prior authorization before they are provided.

When seeking prior authorization, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the Medicaid fee schedule that applies to the date of service to verify whether prior authorization is required for specific services.
- The Prior Authorization Criteria for Specific Services tables on the Prior Authorization Information webpage list services that require prior authorization, who to contact for authorization, and documentation requirements. See the Prior Authorization Information link in the left menu on the Provider Information website.
- When prior authorization is granted, providers receive notification containing a prior authorization number. This prior authorization number must be included on the UB-04 claim form.
- Providers must comply with all requirements for Medicaid prior authorization before providing services or before payment, as applicable to the particular category of services being provided.

Different codes are issued for Passport approval and prior authorization, and both must be recorded on the UB-04.

Medicaid does not pay for services when Passport or prior authorization requirements are not met.

Coordination of Benefits

The following is specific to RHCs/FQHCs. In addition, providers should refer to the section on Third Party Liability in the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

Medicare Claims

Medicare covers RHC and FQHC covered services. These claims automatically cross over from Medicare for dually-eligible members, so providers do not need to send in their crossovers on paper. The Department's fiscal agent must have the provider's Medicare number on file to process claims, and providers should include their NPI/API on their Medicare claims.

RHC claims that cross over to Medicaid are paid the Medicare coinsurance and deductible less any TPL coverage.

FQHC claims that cross over to Medicaid are paid the difference between the FQHC Medicaid-specific all-inclusive rate and what Medicare paid.

Other Programs

MHSP services are allowed for RHCs and FQHCs. Providers can find information on Medicaid mental health services and MHSP services in the mental health manual available on the Provider Information website.

The information in this chapter does not apply to members enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana at 1-800-447-7828. Information about HMK is available on the HMK website.

Billing Procedures

The following is specific to RHCs/FQHCs. In addition, providers should refer to the Billing Procedures chapter in the *General Information for Providers* manual.

Claim Forms

RHC and FQHC services must be billed either electronically or on a UB-04 claim form. UB-04 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Member Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing for RHC and FQHC services is $5.00 per visit. See the *General Information for Providers* manual for additional information on member cost sharing.

Cost sharing for RHC and FQHC services is $5.00 per visit.

Coding for RHCs/FQHCs

The following is specific to RHCs/FQHCs. See the *General Information for Providers* manual for additional information.

RHCs and FQHCs must use the following revenue codes as specified by the Department. Check with Provider Relations to make sure they are valid for your facility. If invalid for your clinic, the use of these revenue codes will result in non-payment.

B	512	Dental
B	521	RHC/FQHC clinic visit
B	522	RHC/FQHC home visit
B	524	Visit by RHC/FQHC practitioner to a member in an covered Part A stay at a skilled nursing facility
B	525	Visit by RHC/FQHC practitioner to a member in a skilled nursing facility (not a covered Part A stay) or nursing facility or intermediate care facility for the mentally retarded or other residential facility
B	527	RHC/FQHC visiting nurse services to a member's home when in a home health shortage area
B	528	Visit by an RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)
B	636	HMK vaccine reimbursements
B	771	HMK non-visit vaccine administration fee
B	780	Telehealth originating site
B	900	Mental health visits

Number of Lines on Claim

Clinic claims are reimbursed using an all-inclusive rate of payment per visit. Only one line per claim will receive payment, except in the case of HMK vaccination vaccine and administration fees, which can pay per line. See page 2.6 for information on HMK vaccination billing.

Multiple Services on Same Date (ARM 37.86.4402)

A clinic visit is defined as a face-to-face encounter between a clinic patient and a clinic healthcare professional for the purpose of providing clinic core or other ambulatory services or billable incidental services. Encounters with more than one clinic healthcare professional, and multiple encounters with the same clinic healthcare professional, on the same day at a single location constitute a single visit except when one of the following exists:

- After the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment, or
- The patient has a medical visit and a mental health visit, or a medical visit and a dental visit, or a mental health visit and a dental visit.

Span Bills

Span billing is not allowed for RHCs and FQHCs. Providers may bill for only one date of service per claim. Spans greater than one date of service in FL 6 will result in payment for one date of service. Reimbursement of other dates of service within the span is not possible until the paid claim is adjusted to reflect one date of service only.

Using Modifiers

When billing on a UB-04, the Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen in FL 44. For example, Code 25680 (treatment of wrist fracture) when done bilaterally is reported as Code 2568050.

Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first.

Service Settings

Clinic services are covered when provided in an outpatient setting including the clinic, other medical facility (including a dental office) or a patient's place of residence. A patient's place of residence may be a nursing facility or other institution used as the patient's home. Clinic services are covered off site as long as the service is normally furnished within the scope of the clinic's professional services. Services provided off site are part of the clinic benefit if the provider has an agree-

ment with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic does not compensate the provider for services provided off site, the clinic may not bill Medicaid for those services.

FQHCs and RHCs must not bill in the hospital setting. FQHC and RHC providers that perform services in a hospital setting must bill the service on a CMS-1500 using their own provider number. Pre- and post-visits at the clinic are billed by the clinic on a UB-04 as a core service.

Other Programs

Healthy Montana Kids (HMK)

The information in this chapter applies to HMK for RHC and FQHC clinic services.

Providers may bill HMK revenue codes 512, 521, 636, 771, and 900. Providers billing for HMK dental services must be enrolled as HMK dental providers.

Since HMK-enrolled children are not entitled to the Vaccines for Children (VFC) program, providers may bill Montana Medicaid for vaccines using revenue code 636 and the vaccine procedure code. If a child receives a physician or mid-level visit, vaccines will be paid and administration fees will bundle with the visit fee and pay at zero. If vaccines are administered without a physician or mid-level visit, providers may also bill for vaccine administration fees using revenue code 771 and vaccine administration procedure codes. An immunization-only visit does not qualify for a visit fee.

For more information, contact BCBSMT at 1-800-447-7828. Additional information regarding HMK is available on the HMK website.

Submitting a Claim

The services described in this manual are billed on UB-04 claim forms. Please use this chapter with the UB-04 claim instructions on the Provider Information website.

Claims are completed differently for the different types of coverage a member has. Claims submitted with all of the necessary information are referred to as *clean* and are usually paid in a timely manner. (See the Billing Procedures chapter in the *General Information for Providers* manual.)

Passport and Cost Sharing Indicators

Passport to Health Indicators	
Code	**Description**
FPS	This indicator is used when providing family planning services.
OBS	This indicator is used when providing obstetrical services.
TCM	This indicator is used when providing targeted case management services.
Cost Sharing Indicators	
C	This indicator is used when providing services to a child or EPSDT exempt.
E	This indicator is used when providing emergency services.
F	This indicator is used when providing family planning services.
P	This indicator is used when providing services to pregnant women.

Unless otherwise stated, all paper claims must be mailed to the following address:

Claims
P.O. Box 8000
Helena, MT 59604

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double-check each claim form to confirm items are accurate. For more information on returned and denied claims, see the Billing Procedures chapter.

Common Claim Errors

See the section titled The Most Common Billing Errors and How to Avoid Them in the *General Information for Providers* manual.

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For more information, contact BCBSMT at 1-800-447-7828. Additional information regarding HMK is available on the HMK website.

Remittance Advices and Adjustments

See the *General Information for Providers* manual for information on remittance advices and adjustments.

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to Montana Medicaid, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

RHCs and FQHCs

RHCs and FQHCs are reimbursed for their costs of providing care using a prospective payment system. This payment allows for one all-inclusive rate of payment per visit. In the initial reporting period, the all-inclusive visit rate is adopted by Medicaid based on the Medicare rate for the RHC/FQHC facility. After two full years that cost reports are filed with Medicaid, a review of the rate is performed and adjusted as necessary to cover the facility's costs. Each year, the Centers for Medicare and Medicaid Services (CMS) mandates that all RHC/FQHC rates are increased by the Medicare Economic Index (MEI). This payment is the same for core, other ambulatory and billable incidental services.

Reimbursement Rates for Change in Scope of Service (ARM 37.86.4406)

Change in Scope of Service

The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and/or amount of services provided by a health center. CMS's broad definition of change in scope allows the Department the flexibility to develop a more precise definition of what qualifies as a change in scope as it relates to the type, intensity, duration, and amount for implementing these adjustments.

A change in the scope of RHC/FQHC services may occur if the facility has added, dropped, or expanded any service that meets the definition of an RHC/FQHC service as defined by 42 USC 1396d(a)(2)(B–C).

A change in the cost of a service is not considered in and of itself a change in the scope of service. An RHC/FQHC must demonstrate how a change in the scope of service impacts the overall health center rather than focus on the specific change alone. For example, a health center may increase services to high-need population; however, this increase may be offset by growth in the number of lower intensity visits. A health center needs to demonstrate an overall change to the health center's services.

The following are examples that may be recognized as a change in scope of service. Other situations may apply that are not addressed in this document.

- A change in scope of services from what was initially reported and incorporated in the baseline PPS rate. Examples include changes within medical, dental, or mental health service areas.
- A change in the scope of services resulting from a change in the types of health center providers. A change in providers alone without a corresponding change in scope of service does not constitute as an eligible change. Some examples of eligible changes include:
  - A transition from mid-level providers (e.g., nurse practitioners) to physicians with a corresponding change in scope of services provided by the health center.
  - The addition or removal of specialty providers (e.g., pediatric or obstetric specialist) with a corresponding change in scope of services provided by the health center (e.g., delivery services). If a health center reduces providers with a corresponding removal of services, there may be a decrease in the scope of services.
- If a health center hires providers to provide services that were referred outside of the health center, there may be an increase in the scope of services.

- A change in service intensity or service delivery model attributable to a change in the type of patients served including, but not limited to, homeless, elderly, migrant, or other special populations. A change in the types of patients served alone is not a valid change in the scope of services. A change in the type of patients served must correspond with a change in scope of services provided by the health center.
- Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the health center services including new or expanded service facilities. A change in capital expenditures must correspond with a change in scope of services (e.g., the addition of a radiology department).

The following do not qualify as a change in scope of services:

- A change in office hours;
- Adding staff for the same service mix provided;
- A change in office location or office space; or
- A change in the number of patients served.

If an FQHC/RHC has experienced an increase or decrease in the health center's scope of services, a written narrative describing the specific changes in health center services and how these changes relate to a change in the health center's overall operation is required. An estimate of billable Medicaid visits for the forthcoming 12-month period and associated cost expenses should be included in the narrative. All costs and expenses reported must be in agreement with the principles of reasonable cost reimbursement as found in 42 CFR 43, Publication 15-1, and any other regulations mandated by the federal government.

How Payment Is Calculated

TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability (TPL). In these cases, the other insurance is the primary payer (as described in the Coordination of Benefits chapter of this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

For example, a provider submits an RHC or FQHC claim for $120.00 for a member with Medicaid and TPL. The Medicaid allowed amount is $106.58. The other insurance company paid $95.05. This amount is subtracted from the Medicaid allowed amount leaving $11.53. Medicaid pays $11.53 for this claim. If the TPL payment had been $106.58 or more, this claim would have paid at $0.00.

Medicare Crossover Claims for RHCs

When an RHC member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on RHC claims for these dually eligible individuals.

For example, an RHC provider submits a claim for a member with Medicare and Medicaid. The Medicare coinsurance and deductible total $11.78. This total ($11.78) becomes the Medicaid allowed amount. Medicaid will pay this amount ($11.78) as long as no TPL or incurment amounts are applicable.

Medicare Crossover Claims for FQHCs

When an FQHC member has coverage from both Medicare and Medicaid, Medicare is the primary payer, but any Medicare payment is treated like a TPL payment. Medicaid will make a payment only when the Medicare payment is less than the Medicaid allowed amount.

For example, an FQHC provider submits a claim for $55.00 for a member with Medicare and Medicaid. The Medicaid allowed amount is $106.58. Medicare paid $75.58. This amount is subtracted from the Medicaid allowed amount leaving $31.00. Medicaid pays $31.00 for this claim. If the Medicare payment had been $106.58 or more, this claim would have paid at $0.00.

The exception to this payment logic would be when a member has QMB (Qualified Medicare Beneficiary). When a member has QMB, Medicaid will pay the coinsurance and deductible.

Other Programs

The information in this chapter does apply to HMK enrolled children when billing for dental, eyeglasses, RHC/FQHC clinic services, or community-based psychiatric rehabilitation services. For more information, contact Blue Cross and Blue Shield at 1-800-447-7828 and visit the HMK website.

Appendix A: Forms

See the Forms page of the Montana Healthcare Programs Provider Information website for the forms listed below.

- Individual Adjustment Request
- Medicaid Abortion Certification (MA-37)
- Informed Consent to Sterilization (MA-38)
- Medicaid Hysterectomy Acknowledgment (MA-39)

Definitions and Acronyms

For definitions and acronyms, see the Definitions and Acronyms link in the menu on the Provider Information website.

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