Federally Qualified Health Center Payment Process

Quick Reference Guide

FQHC PPS Payment Process & Methodology

Ambetter from Superior HealthPlan will initiate claims system changes for Federally Qualified Health Center (FQHC) claims with dates of service in 2016 and later. The changes will align with the Department of Health and Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS) contract amendment and direction related to FQHC payments, which include required claims elements for reimbursement of FQHC claims at a Fee for Service (FFS) unless contracted for Prospective Payment System (PPS) Encounter Rate, and encounter submission to CMS for Superior reimbursement of All-Inclusive Rate (AIR) payment amounts, which are updated annually every calendar year.

To maintain consistent claims processes for FQHCs, **Ambetter** claims have to be billed using the requirements listed below:

General Claims Requirements

- Claim Form: CMS 1450/UB04 or CMS 1500
- CMS 1450/UB04 (For providers with Medicare encounter language)
  - Type Of Bill (TOB) FQHC – 77X
  - Field 42: Revenue Codes (52X, 900)
  - Field 44: HCPCS and Modifier (if applicable) for FQHC Visit
    - G0466, G0467, G0468, G0469, G0470
    - Modifier 59: when billing for a subsequent injury or illness
  - Field 45: Date of Service
    - A single date must be reported on a line item
  - Field 46: Units for each type of service
    - Only one visit is billed per day unless the patient leaves and later returns with a different illness on the same day
  - Field 56: Billing Provider NPI
    - When more than one encounter/visit is reported on the same claim. (Choose NPI of the provider that furnished the majority of the services)
- CMS 1500 (For providers with Medicaid encounter language)
  - Location Code: 50
  - HCPC: T1015 with appropriate modifiers when applicable and a PPS rate on first service line of the claim form in addition to appropriate procedure codes for services provided (including all applicable modifiers and the provider's usual customary charge.
  - Field 24I/J: Rendering/servicing provider NPI/taxonomy if required.
  - Field 33A/B: Billing provider's NPI/Taxonomy
- CMS 1500 (For providers with payor or current year Medicare fee for service)
  - Location Code: 11, 50, 72
  - HCPCs/CPT:
    - G0466 – must be accompanied with the qualifying visit code (92002, 92004, 97802, 99201-99205, 99324-99325, 99328, 99341-99345, 99381- 99387, 99406, 99407, G0101, G0102, G0108, G0117, G0118, or G0442-G0447)
    - G0467 – must be accompanied with the qualifying visit code (92012, 92014, 97 802, 97803, 99211-99215, 99304-99310, 99315, 99316, 99318, 99334-99337, 99347-99350, 99391-99397, 99406, 99407, 99495, 99496, G0101, G0102, G0108, G0117, G0118, G0270, or G0442-G0447)
    - G0470 – Mental Health Visit