Revision Date: 8/25/22; 7/12/21; 7/26/2019; 5/23/2018; 4/13/2018; 03/01/2017; 10/15/2015; 4/1/2015

## Background

Effective for dates of service on and after 04/01/2015 AHCCCS pays the all-inclusive per visit PPS rate on a per claim basis for providers registered as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), replacing the previous method of reimbursing claims reported under individual FQHC/RHC employed practitioners by the capped fee-for-service fee schedule and annually reconciling to the PPS rate. The method for calculating the all-inclusive per visit PPS rates will not change.

AHCCCS will continue to perform annual reimbursement reconciliations. Additionally, AHCCCS anticipates that quarterly supplemental payments will continue, though in amounts appropriate to the expectation that the MCOs will, in most cases, be paying the PPS rate. MCOs may continue to establish sub-capitated reimbursement arrangements.

A provider designated by CMS as an FQHC or FQHC Look-Alike (FQHC-LA) will be registered by AHCCCS with an AHCCCS provider type of C2 (FQHC). A provider designated by CMS as an RHC will be registered by AHCCCS with an AHCCCS provider type of 29 (RHC). To be eligible for the PPS per visit rate claims must be reported under the FQHC or RHC.

## Definitions

"FQHC/RHC visit" means: A 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.

Services "incident to" a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician's or practitioner's professional service (examples: medical supplies; venipuncture; assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services
(Examples: x-ray; medication; laboratory test).

## Behavioral Health

- **Case Management**
  - o Effective with dates of service on and after 10/01/2015, AHCCCS will not recognize case management as a PPS-eligible service.  To the extent that case management services are reimbursable, they will be reimbursed according to the Capped FFS Fee Schedule.
- **Group Therapy**
  - o Group therapy does not qualify as an FQHC service, since it is not a face-to-face encounter. For a visit to qualify as a face-to-face encounter the visit must be one-on-one, disqualifying group therapy from being a PPS-eligible service.

## Billing Guidelines

*Please note:  FQHC pharmacy billing will remain under the pharmacy provider type and is not impacted by this change.*

For dates of service on and after 04/01/ 2015, in order to qualify for PPS reimbursement all FQHC, FQHC-LA, and RHC providers must utilize the appropriate NPI for the FQHC or RHC as the rendering provider for the claim (Note: PPS reimbursement will only apply to the FQHC or RHC provider). For electronic billing applicable reporting standards apply (Billing Provider Loop – Required, sent for every transaction and Rendering Provider Loop – Situational, sent if the rendering provider is different than the billing provider).

PPS visits must be billed on a Form 1500, 837P professional format, ADA Form or 837D dental format as appropriate to the type of PPS eligible visit and utilize appropriate place of service coding. Place of service codes for inpatient settings are not appropriate for FQHC/RHC billing.

For purposes of reimbursing PPS eligible visits, AHCCCS has adopted the T1015 (Clinic visit/encounter, all-inclusive) procedure code for FQHC physical, behavioral health and dental visits. This procedure code should be reported on all claims to designate an FQHC/RHC visit and receive PPS reimbursement.

Billed charges associated with the T1015 procedure code should reflect the appropriate PPS rate for the FQHC/RHC to ensure full PPS reimbursement. If something less than the PPS rate is used to report billed charges for the T1015 visit code, the AHCCCS "lesser of" reimbursement policy will prevail and cause the claim to be paid a rate less than the PPS rate.

There is an allowed exception for an approved Special Health Care District (formerly known as an FQHC-Look Alike) to default to $0.00 billed charges for the T1015 code and still pay the applicable PPS rate.

A visit is identified by, and reimbursement for the visit is associated with, the T1015 code; all other covered services reported on the claim are bundled into the visit and valued at $0.00 for reimbursement purposes.

In addition to the T1015 PPS visit code, claims must continue to include all appropriate covered procedure codes (including appropriate E&M codes) describing the services rendered as part of the visit. If no covered procedure codes are reported in conjunction with the T1015 visit code or if there is no T1015 visit code reported, no PPS reimbursement will apply.

For dates of service on and after 04/01/ 2015, traditionally global services such as deliveries and/or surgery pre- and post-op days will no longer be treated as packages; however, they will be eligible for PPS visit reimbursement and, therefore, will require split billing.

Services which do not accompany a visit but are "incident to" that visit based upon the definition (lab, radiology, immunizations or other testing) are not separately reimbursed.

Multiple visits on the same day within the same discipline which are distinct based upon the FQHC/RHC visit definition above must be identified by billing the T1015 visit code for the same-day subsequent visit with a modifier 25 to indicate a distinct and separate visit.

In order to retain information related to the actual professional practitioner (provider) participating in/performing services associated with PPS visits, that professional practitioner (provider) participating in/performing services must also be reported on all claims as outlined below.

## Behavioral Health Technician (BHT)

Behavioral Health Technician (BHT) services, excluding case management, may qualify as an FQHC/RHC visit when those services qualify as services incident to the services of an FQHC/RHC practitioner consistent with 42 CFR 405.2462.

## Telehealth and Telemedicine

Telehealth and telemedicine may qualify as an FQHC/RHC visit if it meets the requirements specified in AMPM 320-I, Telehealth and Telemedicine. To qualify as a reimbursable telehealth visit, claims with procedure code T1015 must additionally include another eligible code from the AHCCCS Telehealth Code Set.

## Instructions for Billing Participating/Performing Professional Practitioner:

CMS Form 1500 (Paper/Web Claim): Field 19 - Additional Claim Information

Format Examples:

One Participating/Performing Provider – XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first, 20 characters)
Example –
XX1987654321Smitherhouse, Michelle

Two Participating/Performing Providers –
XXNPIProviderName (NPI if a registerable Provider) or
9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)
3 blanks XXNPIProviderName (NPI if a registerable Provider) or
9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)
Example – XX1987654321Smitherhouse, Michelle  XX2123456789Fredricksburg, Cynthia

ADA Form (Paper/Web Claim): Field 35. Remarks

Format Examples:

One Participating/Performing Provider - XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)
Example –
XX1987654321Smitherhouse, Michelle

Two Participating/Performing Providers –
XXNPIProviderName (NPI if a registerable Provider) or
9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)
3 blanks XXNPIProviderName (NPI if a registerable Provider) or
9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)

Example –
XX1987654321Smitherhouse, Michelle  XX2123456789Fredricksburg, Cynthia

837 Professional (Electronic Claim): 2300 NTE

Format Examples:

One Participating/Performing Provider – XXNPI ProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)

Two Participating/Performing Providers – XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider)(last, first 20 characters) 3 blanks XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider)(last, first 20 characters)

| Loop | Element | Description 837-P 5010 A1 ENC | ID | Min. Max. | Use | Note | AHCCCS Usage/Expected Value (Codes/Notes/Comments) |
|---|---|---|---|---|---|---|---|
| **2300** | **NTE** | **CLAIM NOTE** | | **1** | **S** | | |
| 2300 | NTE01 | Note Reference Code | ID | 3-3 | R | ADD=Additional Information CER=Certification Narrative DCP=Goals, Rehabilitation Potential, or Discharge Plans DGN=Diagnosis Description TPO=Third Party Organization Notes | Expect 'ADD' – Additional Information |
| 2300 | NTE02 | Claim Note Text | AN | 1-80 | R | Expect Claim Note Text | One Participating Provider XXNPIProviderName or 9999999999ProviderName Two Participating Providers or Performing ProvidersXXNPIProviderName or 9999999999ProviderName 3 blanks XXNPIProviderName or 9999999999ProviderNameMITHERHOUSE, MICHELLE XX2123456789FREDRICKBURG, CYNTHIA |

837 Dental (Electronic Claim): 2300 NTE

Format Examples:

One Participating/Performing Provider – XXNPI ProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)

Two Participating/Performing Providers – XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider)(last, first 20 characters) 3 blanks XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider)(last, first 20 characters)

| Loop | Element | Description 837-D 5010 A2 ENC | ID | Min. Max. | Use | Note | AHCCCS Usage/Expected Value (Codes/Notes/Comments) |
|---|---|---|---|---|---|---|---|
| **2300** | **NTE** | **CLAIM NOTE** | | **1** | **S** | | |
| 2300 | NTE01 | Note Reference Code | ID | 3-3 | R | ADD=Additional Information CER=Certification Narrative DCP=Goals, Rehabilitation Potential, or Discharge Plans DGN=Diagnosis Description TPO=Third Party Organization Notes | Expect 'ADD' – Additional Information |
| 2300 | NTE02 | Claim Note Text | AN | 1-80 | R | Expect Claim Note Text | One Participating Provider XXNPIProviderName or 9999999999ProviderName<br><br>Two Participating Providers or Performing Providers XXNPIProviderName or 9999999999ProviderName 3 blanks XXNPIProviderName or 9999999999ProviderName |

- <u>Do not</u> enter a space, hyphen, slash or other separator between the qualifier codeand the NPI number or between the NPI and the Provider Name.
- When reporting a second item of data, enter three blank spaces and then the nextqualifier and number/code/Provider Name.
- XX is the actual Qualifier Code designated by the standards body to indicate an NPI.
- At this time reporting of Participating Providers beyond 2 occurrences is not supported as defined in the standards for these transactions.  If ParticipatingProviders beyond 2 occurrences exist for a single claim, only the first two occurrences should be reported.

### Reporting School Site Information as an FQHC/RHC

In the event an FQHC/RHC provides services at a school place of service, the FQHC/RHC must also comply with the following guidelines for reporting the school site. The FQHC/RHC shall list themselves as the rendering provider. Additionally, the School Identifier as well as the participating provider shall be entered on the claim form. A listing of the school 9-digit CTDS identifier codes will be provided on the AHCCCS Medical Coding Resources webpage.

FQHCs should report one participating provider as outlined above, followed by 3 spaces then the applicable Identifier and values for the School Identifier.

School Identifier: OB (State License) followed by 9 Digit School ID
OB*NNNNNNNNN*

Example

| One Participating/Performing Provider – |
|---|

0BNNNNNNNNN XXNPI/Provider Name
                OR
XXNPI/Provider Name  0BNNNNNNNNN

FQHCs should report two participating providers as outlined above, followed by 3 spaces then the applicable Identifier and values for the School Identifier.

School Identifier: OB (State License) followed by 9 Digit School ID
OB*NNNNNNNNN*

Example

| Two Participating/Performing Providers – |
|---|

0BNNNNNNNNN XXNPI/Provider Name XXNPI/Provider Name
                OR
XXNPI/Provider Name  XXNPI/Provider Name   0BNNNNNNNNN.

- Do not enter a space, hyphen, slash or other separator between the qualifier code and the number.
- 0B is the Qualifier Code designated by the standards body to indicate a State License.

## Billing Examples

Examples 1500:

Example Claim #1 – (based on actual services to a member on the same day) (may be billed on multiple claim forms or a single claim form)

PROC: 99202            PROC: T1015            PROC: 84005
MOD:                   MOD:                   MOD: 26
UNITS: 1.000           UNITS: 1.000           UNITS: 1.000
BILLED CHRGE:  114.00  BILLED CHRGE:  160.00  BILLED CHARGE:  24.00
PAY:  0.00             PAY:   PPS Rate (or    PAY:  0.00
                       Billed Charge if less)

Example Claims #2 and #3 – (based on actual services for the same member over a period of time) (each claim example may be billed on multiple claim forms or a single claim form)

BEGIN/END DATES OF SERVICE – 5/1/2015
PROC: T1015            PROC: 99213            PROC: 84005
MOD:                   MOD:                   MOD: 26
UNITS: 1.000           UNITS: 1.000           UNITS: 1.000
BILLED CHRGE:  160.00  BILLED CHRGE:  90.00   BILLED CHARGE:  90.00
PAY:   PPS Rate (or    PAY:  0.00             PAY:  0.00
**Billed Charge if less)**

BEGIN/END DATES OF SERVICE – 6/10/2015
PROC: T1015            PROC: 99213            PROC: 74000
MOD:                   MOD:                   MOD: 26
UNITS: 1.000           UNITS: 1.000           UNITS: 1.000
BILLED CHRGE:  160.00  BILLED CHRGE:  90.00   BILLED CHARGE:  90.00
PAY:   PPS Rate (or    PAY:  0.00             PAY:  0.00
Billed Charge if less)

Example Claim #4 – (No T1015 billed)

PROC: 99213            PROC: 74000
MOD:                   MOD:
UNITS: 1.000           UNITS: 1.000
BILLED CHRGE:  114.00  BILLED CHARGE:  124.00
PAY:  0.00             PAY:  0.00

Examples ADA:

Example Claim #1 – (based on actual services to a member on the same day) (may be billed on multiple claim forms or a single claim form)

| | | |
|---|---|---|
| PROC: D7111 | PROC: T1015 | PROC: D0220 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| TOOTH NUMBER: J | TOOTH NUMBER: | TOOTH NUMBER: J |
| SURFACE: | SURFACE: | SURFACE: |
| ORAL CAVITY: | ORAL CAVITY: | ORAL CAVITY: |
| BILLED CHRGE: 114.00 | BILLED CHRGE: 160.00 | BILLED CHARGE: 24.00 |
| PAY: 0.00 | PAY: PPS Rate (or Billed Charge if less) | PAY: 0.00 |

Example Claims #2 and #3 – (based on actual services for the same member over a period of time) (each claim example may be billed on multiple claim forms or a single claim form)

BEGIN/END DATES OF SERVICE – 5/1/2015

| | | |
|---|---|---|
| PROC: T1015 | PROC: D2392 | PROC: D0220 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| TOOTH NUMBER: | TOOTH NUMBER: 28 | TOOTH NUMBER: 29 |
| SURFACE: | SURFACE: O D | SURFACE: O D |
| ORAL CAVITY: | ORAL CAVITY: | ORAL CAVITY: |
| BILLED CHRGE: 160.00 | BILLED CHRGE: 90.00 | BILLED CHARGE: 90.00 |
| PAY: PPS Rate (or Billed Charge if less) | PAY: 0.00 | PAY: 0.00 |

BEGIN/END DATES OF SERVICE – 6/10/2015

| | | |
|---|---|---|
| PROC: T1015 | PROC: D2392 | PROC: D0220 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| TOOTH NUMBER: | TOOTH NUMBER: 28 | TOOTH NUMBER: 29 |
| SURFACE: | SURFACE: O D | SURFACE: O D |
| ORAL CAVITY: | ORAL CAVITY: | ORAL CAVITY: |
| BILLED CHRGE: 160.00 | BILLED CHRGE: 90.00 | BILLED CHARGE: 90.00 |
| PAY: PPS Rate (or Billed Charge if less) | PAY: 0.00 | PAY: 0.00 |

BEGIN/END DATES OF SERVICE – 6/10/2015

| | |
|---|---|
| PROC: D2392 | PROC: D0220 |
| UNITS: 1.000 | UNITS: 1.000 |
| TOOTH NUMBER:   28 | TOOTH NUMBER: 29 |
| SURFACE:   O D | SURFACE:  O D |
| ORAL CAVITY: | ORAL CAVITY: |
| BILLED CHRGE:  90.00 | BILLED CHARGE:  90.00 |
| PAY:  0.00 | PAY:  0.00 |

For additional examples related to areas including EPSDT visits; multiple visits on the same date of service; global billing situations; Medicare and OTI primary, please refer to the FQHC/RHC page on the AHCCCS website at the following link:
https://www.azahcccs.gov/PlansProviders/Downloads/FFSrates/FQHC/FQHC-RHCAdditionalBillingExamples.pdf

## FFS Billing Instructions with a Primary Payer

When Medicare is primary payer
Crossover claims are received electronically from the Medicare plan with Medicare's specified coding, which will not match to AHCCCS coding requirements.

The FQHC/RHC provider must first void the crossover claim and then submit on a 1500 claim form with the AHCCCS specified coding and include a copy of the EOMB.

On the 1500 claim form Medicare's deductible/coinsurance/copay total amounts *must* be reported on the T1015 claim line for reimbursement in the correct Medicare fields. The appropriate EM codes must be billed on successive lines with 0.00 billed amounts, while leaving the Medicare fields blank (do *not* enter 0's).

If the Medicare claim did not crossover, the FQHC/RHC must submit the claim with the EOMB, even though the codes billed will not match the EOMB. The Medicare deductible/coinsurance/copay total amounts *must* be reported on the T1015 service line, in the correct Medicare fields, for reimbursement. The appropriate EM codes must be billed on successive lines with 0.00 billed amounts, leaving the Medicare deductible/coinsurance /copay fields blank (do *not* enter 0's).

When other coverage paid as primary
The full other coverage payment paid by the other primary payer will be associated with the T1015 service line only.

The appropriate EM codes must be billed on successive lines with 0.00 billed amounts. A copy of the primary payer's EOB must be included with the claim.  Since AHCCCS specifies the T1015 coding, the billing and the EOB coding will not match.

## References

For information on billing with a 638 FQHC please refer to Chapter 20, 638 FQHC, of the IHS/Tribal Provider Billing Manual.

## Revision/Update History

| Date | Description of changes | Page(s) |
|---|---|---|
| 8/25/2022 | Updated clarification for use of code T1015 with telehealth and telemedicine services. | 3 |
| 7/12/2021 | Language updated to clarify designation of Special Health Care District (formerly known as an FQHC-Look Alike)<br>Reporting school site information as an FQHC/RHC section added | 3<br><br>7 |
| 7/26/2019 | Language updated to include a clarification: "There is an allowed exception for an approved FQHC-Look Alike (FQHC-LA) to default to  $0.00 billed charges for the T1015 code and still pay the applicable PPS rate." | 2 |
| 5/23/2018 | BHT services section added<br>Telehealth/telemedicine services sections added<br>References section added | 3<br>3<br>10 |
| 4/13/2018 | Group therapy statement added under Behavioral Health section | 2 |
| 03/01/2017 | Updated Definition to indicated "registered" AHCCCS practitioner<br>Added Behavioral Health Case Management language effective 10/01/2015<br>Updated Place of Service language<br>Updated directions for covered non-registerable Providers<br>Corrected website link<br>Minor formatting corrections | 1<br>2<br>2<br>3 – 6<br>9<br>Various |
| 10/15/2015 | Correction:  Paper/Web Claims<br>For clarification, added new section "FFS  Billing Instructions with a Primary Payer" | 3<br>8,9 |

| 04/01/2015 Effective | FQHC/RHC Addendum | All |
|---|---|---|
| | | |