Medi-Cal Provider Training 2016

FQHC, RHC & IHS/MOA Services

The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP's easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at http://www.medi-cal.ca.gov/education.asp.

Free Services for Providers

Provider Seminars and Webinars

Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives

The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit

The four SPBU Specialists are dedicated to providing one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the SPBU Billing Assistance and Training Program, call 916-636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

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FQHC, RHC & IHS/MOA Services

Introduction

Purpose

The purpose of this module is to provide information for billing services rendered by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Services (IHS)/Memorandum of Agreement (MOA) clinics to participants in the Medi-Cal program.

Module Objectives

- Define FQHC and RHC
- Explain the IHS/MOA program
- Give billing tips to prevent claim denials
- Discuss billing codes
- Review billing examples
- Identify frequently asked questions
- Top Ten Denials

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (*www.medi-cal.ca.gov/mcss*).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

OBRA and IRCA (obra)

Part 2

Community Based Adult Services (CBAS) (community)
Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, *Clinics* (ind health)
Medicare/Medi-Cal Crossover Claims: Outpatient Services (medi cr op)
Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples (medi cr op ex)
Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural)
Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Examples (rural ex)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

NOTES

Description

FQHCs and RHCs provide outpatient health care services to subscribers, recipients and clients in rural and non-rural areas. IHS/MOA clinics primarily provide health care services to Medi-Cal recipients of American Indian or Alaskan ancestry.

FQHC Program

FQHCs were added as a Medi-Cal provider type in response to the Federal Omnibus Budget Reconciliation Act (OBRA) of 1989.

RHC Program

A Rural Health Clinic extends Medicare and Medi-Cal benefits to cover health care services provided by clinics operating in rural areas. RHCs are located in federally designated medically-underserved areas or medically-underserved population locations as prescribed by Health Resources Services Administration (HRSA)

All RHCs must meet certain federal requirements to be certified. An RHC employs or contracts with nurse practitioners, physician assistants and certified nurse midwives, who provide services at the clinic at least 50 percent of the time the RHC is open. RHC physicians may work less than full-time as long as the physician is present in the clinic during operating hours.

IHS/MOA

On April 21, 1998, DHCS implemented the IHS/MOA between the federal IHS and the Centers for Medicare & Medicaid Services. The IHS/MOA changed the reimbursement policy for services provided to Medi-Cal recipients within American Indian or Alaskan native health care facilities identified as 638 facilities. The Department of Health Care Services (DHCS) compiled a list of IHS/MOA clinics and mailed a letter to each provider informing them of the option to participate as a 638 clinic under the MOA. Providers electing to participate were asked to complete and return an *"Elect to Participate" Indian Health Services Memorandum of Agreement (IHS/MOA) Application* (form DHCS 7108) to the DHCS Provider Enrollment Division.

Provider Enrollment

FQHC and RHC Enrollment

Any clinic, hospital or provider can apply to become a part of the FQHC or RHC program. Providers must first contact the Department of Public Health, Licensing and Certification Program to obtain licensure. After obtaining licensure, the provider must contact DHCS Audits and Investigations (A&I) to enroll as an FQHC or RHC. As facilities enroll in the FQHC and RHC programs, they will receive a new National Provider Identifier (NPI) and their current provider numbers will be deactivated.

Authorized Physicians

For FQHC and RHC purposes, the following providers are defined as “physicians”:

Type of Physician	Program Requirements
General Medicine or Osteopathy	The physician is authorized to practice medicine and surgery by the state while acting within the scope of his/her license.
Podiatrist	The physician is authorized to practice podiatric medicine by the state while acting within the scope of his/her license.
Optometrist	The physician is authorized to practice optometry by the state while acting within the scope of his/her license.
Chiropractor	The physician is authorized to practice chiropractics by the state while acting within the scope of his/her license.
Dental Surgeon (Dentist)	The physician is authorized to practice dentistry by the state while acting within the scope of his or her license.

IHS/MOA Enrollment

FQHCs, RHCs and certain Primary Care Clinics (PCCs) designated by the federal IHS as eligible to participate in the IHS/MOA may enroll as IHS/MOA clinic providers.

Clinics cannot be designated as both an IHS/MOA and an FQHC/RHC/PCC provider. Any other current provider numbers or NPIs are deactivated at the time of enrollment. Medi-Cal will recognize these providers as IHS/MOA providers only. All Medi-Cal providers must now have a valid NPI to submit claims to Medi-Cal for services rendered.

Providers may enroll as an IHS/MOA clinic by completing an *“Elect to Participate” Indian Health Services Memorandum of Agreement (IHS/MOA) Application* (form DHCS 7108). The application must be photocopied and mailed to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Faxed applications will not be considered.

Scope of Coverage

Program Type

FQHC/RHC Programs

Types of Services Covered

- Physician services
- Physician assistant services
- Nurse practitioner services
- Certified nurse midwife services
- Visiting nurse services (as defined in *Code of Federal Regulations* [CFR], Title 42, Section 405.2416)
- Comprehensive Perinatal Services Program (CPSP) practitioner services
- Licensed clinical social worker services
- Clinical psychologist services
- Community-Based Adult Services (CBAS)
- Optometry
- Acupuncture** (if the acupuncturist is a doctor of medicine)
- Chiropractic (if the practitioner is authorized to practice chiropractics), a benefit limited to two visits per month

IHS/MOA Program

Types of Services Covered

- Physician services
- Physician assistant services
- Nurse practitioner services
- Nurse midwife services
- Visiting nurse services (only if the IHS/MOA facility is located in an area in which the federal Centers for Medicare & Medicaid Services has determined that there is a shortage of Home Health Agencies)
- Clinical psychologist services*
- Clinical social worker services*
- Marriage and family therapist services*
- Services and supplies incidental to physician services
- CPSP services: registered nurse, dietitian, health education, certified childbirth educator, licensed vocational nurse and comprehensive perinatal health worker
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services: licensed marriage, family and child counselors (available to persons younger than 21 years of age as another health visit if an EPSDT screening identified the need for a service necessary to correct or ameliorate a mental illness or condition)
- Medi-Cal ambulatory services

- Optometry
- Dental**
- Acupuncture**
- Chiropractic**

* Interns must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws.

** Optional Benefit Exclusion: See the *Optional Benefits Exclusion* (opt ben exc) section of the Part 2 provider manual more information about optional benefits.

Treatment Authorization

A *Treatment Authorization Request* (TAR) is not required for services rendered by FQHC, RHC and IHS/MOA programs, but the following conditions apply:

FQHC and RHC	Providers must maintain the same level of documentation that is needed for authorization approval in the patient's medical record. DHCS Audits and Investigations may recover payments that do not meet the requirements under *California Code of Regulations* (CCR), Title 22, Section 51458.1, "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."
IHS/MOA	Providers are required to meet the same documentation requirements that are necessary in a TAR for the same service under Medi-Cal. DHCS A&I may recover payments that do not meet the requirements under *California Code of Regulations* (CCR), Title 22, Section 51458.1, "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."

CPSP Support Services and TARs

CPSP support services in excess of the basic allowances will not be denied for the absence of a TAR; however, the provider is required to maintain the same level of documentation required for authorization. DHCS A&I may recover payments that do not meet the requirements under CCR, Title 22, Sections 51458.1 and 51476.

Required documentation includes:

- Expected date of delivery
- Clinical finding and high-risk factors involved in the pregnancy
- Explanation of why basic CPSP services are not sufficient
- Services that would have been requested
- Anticipated benefit (or result) and outcome (or additional services)
- Length of the visits and frequency with which the requested services were provided

The recipient's medical records should be available for review by DHCS staff. Refer to the specific claim completion section in the appropriate Part 2 Medi-Cal provider manual for more instructions.

Coverage Limitations

Medi-Services

- FQHC/RHC: Two services per month apply when rendered by an FQHC or RHC, similar to fee-for-service Medi-Cal providers.
- IHS/MOA: Limitations apply for services provided in an IHS/MOA clinic, unless the recipient is younger than 21 years of age.

Prescriptions

IHS/MOA clinics may be reimbursed for prescriptions or refills if they are a licensed pharmacy and approved by Medi-Cal to render pharmacy services. If the pharmacy does not qualify, prescriptions or prescription refills are not separately reimbursable with per-visit code 01.

Notice of Changes Regarding Optional Benefits Exclusion for FQHCs and RHCs

Beginning September 26, 2013, three services previously excluded from Medi-Cal coverage – adult dental, chiropractic and podiatric services – became reimbursable Medi-Cal services when provided by FQHCs and RHCs. Chiropractic and podiatric services are subject to a maximum of two services in any one calendar month, or any combination of two services per month among other specified optional services, if provided by an FQHC or RHC, except as otherwise authorized. As of January 1, 2014, psychology services are no longer subject to the two-per-month limit.

More details about this policy were published in the December 2013 Medi-Cal Update bulletins and provider manuals for Clinics and Hospitals and Community-Based Adult Services.

FQHC or RHC Visits (Medical Appointments)

A visit is a face-to-face _____ between an FQHC or RHC _____ and a _____, physician assistant, _____, certified nurse midwife, _____, licensed clinical social worker or _____ (as defined in CFR, Title 42, Section 405.2416), referred to as a "health professional," to the extent the services are reimbursable under the DHCS State Plan.

Reimbursable Visit Criteria	
One Visit	Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the _____, at a single location, constitute a _____.
Two Visits	When a patient – after the _____ – suffers illness or injury that requires another health diagnosis or treatment. When a patient receives CBAS services or is seen by a _____ or CPSP practitioner, and also receives _____ on the same day.

Brainteaser

Clinic visits at which the patient receives services "incident to" physician services (for example, a Laboratory or X-ray appointment) do not qualify as reimbursable visits.

True ☐ False ☐

Answer Key: encounter; recipient/client; physician; nurse practitioner; clinical psychologist; visiting nurse
Answer Key (table): same day; single visit; first visit; health professional; dental services
Answer Key (Brainteaser): True

IHS/MOA Medical Visits

A medical visit is a face-to-face encounter occurring at a clinic or center between a recipient and physician, physician assistant, nurse practitioner, nurse midwife or visiting nurse in certain circumstances.

IHS/MOA clinics may be reimbursed for up to _____ _____per day for _____ _____, if the following conditions are met:

- The first visit is a _____ _____ (per-visit code 01).
- The other visit is either another _____ _____ (per-visit code 23) or a Medi-Cal _____ _____ (per-visit code 24).

Other Types of Visits (Per-Visit Code 23)

Another health visit (per-visit code 23) may be used also for EPSDT program face-to-face encounters between an IHS/MOA recipient/client and a clinical psychologist, clinical social worker or other health professional for therapeutic mental health services.

As of January 1, 2014, psychology services are no longer subject to the two visits per month limit.

- Recipients in Medi-Cal managed care plans, see codes 11 – 17 when services are not covered by the managed care plan.
- A visit with CPSP support staff and/or a pregnancy-related physician encounter on the same day constitutes a single medical visit if the CPSP mental health visit was related to the pregnancy. If the other health visit is unrelated to the pregnancy, an additional visit is allowed with per-visit code 23.

Answer Key: two visits; one patient; medical visit; health visit; ambulatory visit

IHS/MOA: Medi-Cal Ambulatory Visit (Per Visit Code 24)

A Medi-Cal ambulatory visit (per-visit code 24) is a face-to-face encounter between an IHS/MOA recipient and a health care professional other than a physician or mid-level practitioner and is included in California's Medi-Cal State Plan. This encounter must occur in an outpatient setting. Medi-Cal ambulatory visit services are reimbursed at the IHS/MOA all-inclusive rate and are as follows:

Visit Type:	Subject to:
Acupuncture*	CCR, Title 22, Section 51309
Audiology*	
Chiropractic*	
Occupational Therapy	
Physical Therapy	
Podiatry*	
Speech Pathology*	
Drug and Alcohol Visits	Medi-Cal Participation Requirements
Telemedicine	

NOTE
If the recipient, subsequent to the medical or other health or Medi-Cal ambulatory visit, suffers illness or injury requiring additional diagnosis or treatment, an additional visit is reimbursable.

For recipients in Medi-Cal managed care plans, see codes 11 – 17 when services are not covered by the managed care plan.

*Optional Benefit Exclusion: See the *Optional Benefits Exclusion* (opt ben exc) section of the Part 2 provider manual more information about optional benefits.

NOTES

Billing

Crossover Claims

1. Crossover claims should be billed to the FI using _____ _____ with a copy of the _____ _____/MRN/RA attached.
2. A _____ is not included in the crossover reimbursement.
3. Do not complete *Condition Codes* fields (Boxes 24 – 30) for _____ Status.

Dental Services

Dental services are a covered benefit for FQHC, RHC and IHS/MOA providers. Dental services are payable using code 03 for beneficiaries younger than age 21, any pregnant beneficiary with specific aid codes for any age beneficiaries for adults age 21 and older.

Limited adult dental benefits have been reinstated and are no longer excluded under optional benefits for IHS providers. See the Denti-Cal website (*www.denti-cal.ca.gov*) for IHS policy details.

- RHC/FQHC – effective September 26, 2013
- IHS/MOA – effective May 1, 2014

Comprehensive Services for Pregnant Beneficiaries

Effective immediately, pregnant beneficiaries, regardless of age, aid code and/or scope of benefits, are eligible to receive all dental procedures listed in the Denti-Cal Manual of Criteria (MOC) that are covered by the Medi-Cal program as long as all MOC procedure requirements and criteria are met. Beneficiaries are also eligible to receive these services for 60 days postpartum, including any remaining days in the month in which the 60th day falls.

Answer Key: 1) code 02; Medicare EOMB; 2) deductible; 3) Medicare

Federally Required Adult Dental Services (FRADs)

Refer to the Denti-Cal website (*www.denti-cal.ca.gov*) to obtain the Federally Required Adult Dental Services (FRADs) that reflect payable dental services for both pregnant women and adults.

Providers can contact Denti-Cal at 1-800-423-0507. Recipients can contact Denti-Cal at 1-800-322-6384.

Community-Based Adult Services (CBAS) Visit*

_____or more hours of CBAS services must be provided _____ _____ to qualify as a reimbursable CBAS visit. FQHCs and RHCs must render CBAS services according to the requirements of *Welfare and Institutions Code* (W&I Code), Section 14550.5 and CCR, Title 22, Sections 54001 through 54113. In addition, the FQHC or RHC providing care _____ _____ _____ from the Federal Human Resources and Services Administration to provide the CBAS services, and then, only to the extent the CBAS services are included in the DHCS State Plan.

* ADHC services are the subject of a lawsuit. Please refer to the monthly *Medi-Cal Update* bulletins for information about the status of ADHC.

NOTES

Answer Key: Four; per day; must have approval

Health Care Plans

1. FQHCs and RHCs must bill the appropriate _____ _____ _____ (HCP) when rendering services to HCP recipients.
2. The DHCS Fiscal Intermediary (FI) _____ _____ accept these claims unless the billed services are contractually excluded from the plan (for example CBAS services).
3. Providers should contact the appropriate HCP for _____- _____ authorization and billing information.
4. If the providers wish to have their HCP claims reconciled to their Prospective Payment System (PPS) rate at the end of the fiscal year, they must bill a _____ _____ for each HCP paid claim.

Reconciliations

DHCS is required to perform an annual reconciliation of Managed Care, Medicare crossover visits, Healthy Family Program and Medicare Advantage Program to ensure the FQHC/RHC was paid an amount equal to their PPS rate. IHS providers are paid an amount equal to the federal Indian Health Service per-visit rate. Providers are notified when the Reconciliation Request forms are due and directed to the Financial Audits Branch website for the most current forms and instructions.

The code 02 and code 18 rates may be adjusted to more accurately reflect the difference between the Medicare and HCP payments and the PPS rate after the Reconciliation Request form is reviewed by A&I.

NOTES

Answer Key: 1) Health Care Plan; 2) does not; 3) plan specific; 4) code 18

Visit Codes

FQHC/RHC Codes (All-Inclusive Per-Visit)

Code	Visit Type	Explanation
01	Medi-Cal Per Visit	Requires medical justification for more than one visit per recipient per day. For recipients in Medi-Cal managed care plans, see codes 11 – 17.
02	Crossover Claims	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24 – 30) for Medicare Status.
03	Dental Services	N/A
04	Optometry Services	N/A
06	CBAS Regular Day of Service	Minimum four-hour day at the center excluding transportation time. Refer to the *Community-Based Adult Services (CBAS)* section of the appropriate Part 2 provider manual (rural cd).
07	CBAS Initial Assessment Day	With subsequent attendance at the center. Limit of three assessment days. Same center may not bill for assessment days again within 12 months of the last day of service. If the participant transfers to another center, assessment days may be billed by the second center without the 12-month restriction.
08	CBAS Initial Assessment Day	Without subsequent attendance at the center. A statement explaining why the participant did not attend the center subsequent to assessment must be entered in the *Remarks* field (Box 80) of the *UB-04* claim (same limitations as for code 07).
09	CBAS Transition Day	Limit of five days per participant's lifetime. A statement that the *Physician Authorization and Medical Information* form is on file at the center must be entered in the *Remarks* field (Box 80) of the claim.

NOTES

IHS/MOA Codes (All-Inclusive Per-Visit)

Code	Visit Type	Explanation
01	Medi-Cal Per Visit	Requires medical justification for more than one visit per recipient per day. For recipients in Medi-Cal managed care plans, see codes 11 – 17.
02	Crossover Claims	Requires the Medicare *Explanation of Medicare Benefits* (EOMB), *Medicare Remittance Notice* (MRN) or *Remittance Advice* (RA) to be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 18 – 24) for Medicare Status.
03	Dental Services	N/A
04	Optometry Services	N/A
05	Implantable Contraceptive Kit	Use code 01 to bill for insertion or removal of the implantable contraceptive. Codes 01 and 05 may be billed by the same provider for the same recipient on the same date of service. Attach a copy of the invoice to the paper claim.

FQHC/RHC Managed Care Codes (Services Not Covered by Managed Care Plan)

Code	Description	Explanation
11	Licensed Clinical Social Worker (LCSW)	A mental health service rendered by a LCSW for recipients of any age.
12	Psychologist	A mental health service rendered by a psychologist for recipients of any age.
13	Psychiatrist	A mental health service rendered by a psychiatrist for recipients of any age.
15	Acupuncture	An acupuncture service rendered for recipients of any age, if the acupuncturist is a doctor of medicine.
16	Chiropractic	A chiropractic service rendered for recipients of any age, if the practitioner is authorized to practice chiropractics.
17	Heroin Detox	A heroin detox service rendered in accordance with CCR, Sections 51239, 51328 and 51533, if the physician is a doctor of medicine who examines, diagnoses and prescribes treatment for a patient enrolled in a heroin detox program.

IHS/MOA Managed Care Codes (Services Not Covered by Managed Care Plan)

There are a very limited number of managed care plans that cover some or all mental health services, but members who are affiliated with those health plans may be covered by codes 11, 12, 13 and 14.

Code	Description	Explanation
11	Licensed Clinical Social Worker (LCSW)	A mental health service rendered by a LCSW for recipients of any age.
12	Psychologist	A mental health service rendered by a psychologist for recipients of any age.
13	Psychiatrist	A mental health service rendered by a psychiatrist for recipients of any age.
14	Marriage and Family Therapist (MFT)	A mental health service rendered by a MFT for recipients of any age.
15	Acupuncture*	An acupuncture service rendered for recipients of any age.
16	Chiropractic*	A chiropractic service rendered for recipients of any age.
17	Heroin Detox	A heroin detox service rendered in accordance with CCR, Title 22, Sections 51328 and 51533.

*Optional Benefit Exclusion: See the *Optional Benefits Exclusion* (opt ben exc) section of the Part 2 provider manual more information about optional benefits.

FQHC/RHC/IHS/MOA Managed Care Codes (Enrolled Recipients)

FQHC and RHC facilities should use the following code when billing for services rendered to Medi-Cal managed care plan enrollees and the service is covered by the plan.

Code	Description	Explanation
18	Managed Care Differential Rate	FQHC and IHS services covered by a managed care plan and rendered to recipients enrolled in Medi-Cal managed care plans. The rate for this code approximates the difference between payments received from the managed care plan(s) and the facility's current PPS/IHS rate. **NOTE** The current billing requirement for code 01 will apply when code 18 is billed. Refer to Figure 1 in the *Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) Billing Examples* section (rural ex) in the Part 2 *Outpatient Services Clinics and Hospitals* provider manual.

Cost reports are not required under the PPS. To equalize the difference between reimbursements from managed care plans and providers' PPS rates, A&I staff will conduct annual revenue reconciliation.

FQHC/RHC/IHS/MOA Straight Medi-Cal Recipients in Capitated Medicare Advantage Plans

Code	Description	Explanation
20	Capitated Medicare Advantage Plans	FQHC/RHC/IHS facilities use per-visit code 20 when billing for services rendered to straight Medi-Cal recipients enrolled in capitated Medicare Advantage Plans. • Requires justification for absence of the Medicare EOMB/MRN/RA from the claim. • A deductible is not included in the crossover reimbursement. • Do not complete *Condition Codes* fields (Boxes 24 and 25) for Medicare status.

NOTES

FQHC Billing Instructions for Dual-Eligible Members

Effective October 1, 2014, the Affordable Care Act mandates a transition from the current Medicare FQHC cost-based reimbursement system to a new Medicare payment methodology that is unique for each FQHC.

This new methodology may result in a Medicare payment for a given service that is greater or less than the current Medi-Cal PPS rate for the FQHC.

Consequently, an FQHC seeking reimbursement for services rendered to Medi-Cal recipients who are also covered by Medicare shall not bill Medi-Cal for Medicare cost-sharing amounts, or crossover payments, when the Medicare payment is equal to or exceeds the Medi-Cal PPS rate, for one of the following per-visit codes:

Code Description

- 02 Crossover claims
- 18 Managed care differential rate
- 20 Capitated Medicare Advantage plans

When Medicare payment does not exceed the Medi-Cal PPS rate, an FQHC can continue to bill Medi-Cal for these per visit codes.

Reconciliation Payments for All-Inclusive Per Visit Codes 02, 18, 20

DHCS, Audits and Investigations Division (A&I) reconciles payments to an FQHC for services performed on or after October 1, 2014, using the A&I annual reconciliation request review process.

- Submit a *Federally Qualified Health Center/Rural Health Clinic Reconciliation Request (DHCS 3097)* no later than 150 days after the end of its fiscal year.
- When completing DHCS 3097, an FQHC should include each crossover payment claim that corresponds to a Medicare payment that does not exceed the Medi-Cal PPS rate for the period beginning on or after October 1, 2014.
- All visits and their corresponding Medicare payments that exceed the Medi-Cal PPS rate should not be included on DHCS 3097.

NOTE

Payments previously received for all-inclusive per-visit codes 02, 18 or 20, will be reconciled during the annual A&I reconciliation process.

For IHS/MOA providers that participate in Medicare as an FQHC, this new methodology may result in a Medicare payment for a given service that is greater or less than the current Medi-Cal IHS/MOA per-visit reimbursement rate. IHS/MOAs (if a Medicare FQHC) seeking reimbursement for services rendered to Medi-Cal recipients who are also covered by Medicare shall not bill Medi-Cal for Medicare cost-sharing amounts or crossover payments when the Medicare payment is equal to or exceeds the Medi-Cal IHS/MOA per-visit reimbursement rate for per visit codes 02, 18, 20.

RHC/FQHC/IHS Billing Tips for Codes 02, 20, 18

Code	Primary	Secondary	Remarks – Field 80 or attachment	Additional information
02	Fee-for-Service Medicare Advantage Plan	Fee-for-Service Medi-Cal	Enter this comment into the Remarks field 80: "For a fee-for-service Medi-Cal recipient in a fee-for-service Medicare Advantage Plan"	Attach EOMB/MRN/RA Deductible not included in the crossover reimbursement Do not complete Condition Codes fields (boxes 24-30) for Medicare Status Bill Rate for code 02
20	Capitated Medicare Advantage Plan	Fee-for-Service Medi-Cal (Straight Medi-Cal Recipients)	Enter this comment into the Remarks field 80: "FQHC (or RHC or IHS) Medi-Cal patient enrolled in a Capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO"	Requires justification for absence of the Medicare EOMB/MRN/RA from the claim. Remark information found in Part 2, rural cd, pages 5 & 6 A deductible is not included in the crossover reimbursement. Do not complete Condition Codes fields (boxes 24 & 25) for Medicare status. Bill Rate for code 20
18	Medi-Cal Managed Care differential rate	No Medicare Coverage	EOB not required. No comment required in field 80.	Bill rate for code 18
18	Medi-Cal Managed Care Covered Service by the Plan	Use Code 18 regardless of Medicare eligibility if the primary is Medi-Cal Managed Care. This also applies to Medicare for (dual eligibles) Capitated Medicare	Enter this comment in the Remarks field 80: "FQHC (or RHC) Medi-Cal patient enrolled in a Capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO."	Requires justification for absence of the Medicare EOMB/MRN/RA from the claim. Remark information found in Part 2, rural cd, pages 5 & 6 A deductible is not included in the crossover reimbursement. Do not complete Condition Codes fields (boxes 24 & 25) for Medicare status. Bill Rate for code 18

NOTE

Crossover Claim Completion Instructions are as follows.

- For crossover claims, providers do not complete: *Payer Name* field (Box 50), *Prior Payments* field (Box 54)
- Do not enter prior payment amounts from Medicare or Medicare carrier.

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN, CA 958235555

2

3a PAT. CNTL #
b. MED. REC. #
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
4 TYPE OF BILL: 711
7

8 PATIENT NAME a DOE, JOHN
b
9 PATIENT ADDRESS a
b c d e
10 BIRTHDATE: 08241980
11 SEX: M
12 ADMISSION DATE 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	MEDICAL VISIT	01	100115	1	11000		
001	TOTAL CHARGES						
	PAGE ____ OF ____	CREATION DATE		TOTALS	11000		

50 PAYER NAME: O/P MEDI-CAL
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE: 11000
56 NPI: 0123456789
57 OTHER PRV ID

58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID: 90000000A95001
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: D1D1D1D
0
A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI 1234567890 QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a b c d

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NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Example: Billing Medi-Cal for a Medical Visit for FQHCs, RHCs and IHS/MOAs

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

3a PAT. CNTL # 123456789
4 TYPE OF BILL 711

8 PATIENT NAME b DOE, JANE
9 PATIENT ADDRESS
10 BIRTHDATE 08241980
11 SEX F

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

1	CROSSOVER CLAIM	02	100115	1	7500	
23	001 PAGE ____ OF ____	CREATION DATE		TOTALS	7500	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 7500
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI
77 OPERATING NPI 1234567890
78 OTHER NPI
79 OTHER NPI

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Example: Billing Medi-Cal for a Crossover Claim for FQHCs, RHCs and IHS/MOAs

Managed Care Differential Rate Billing Scenario

John Doe visited a Rural Health Clinic for evaluation of his recent chest pain. He is enrolled in a Medi-Cal managed care plan and the service is covered under the plan. The RHC bills the managed care plan for the encounter. If the managed care plan does not fully reimburse the clinic up to its allowable reimbursement PPS/IHS-MOA rate, the clinic submits a claim-billing code “18” to Medi-Cal for the difference between payments received from the managed care plan rendered on a per-visit basis rate.

Claim-billing code “18” is allowable if the services rendered meet the definition of an eligible Medi-Cal visit by a billable provider. (See billing code “01”.)

This code is used for the Federally Qualified Health Clinics, Rural Health Clinics and Indian Health Clinics.

DHCS calculates the code 18 rate for all Medi-Cal facilities that participate in a Managed Care Plan.

NOTES

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 711

8 PATIENT NAME: b DOE, JOHN

10 BIRTHDATE: 08241980
11 SEX: M
17 STAT: 80

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

1	MANAGED CARE DIFFERENTIAL RATE	18	100115	1	45 00	
23	001 PAGE ____ OF ____	CREATION DATE		TOTALS	45 00	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 45 00
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI
77 OPERATING NPI 1234567890
78 OTHER NPI
79 OTHER NPI

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Example: Managed Care Differential Rate (Code 18)

Frequently Asked Questions (FAQs)

1. **What is an RHC?**

   An RHC is an _____ _____ _____ _____ serving Medicare and Medicaid recipients in rural, medically underserved areas (MUA). Refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section (rural) in the appropriate Part 2 provider manual.

2. **What are the requirements for becoming an FQHC?**

   Providers automatically qualify as an FQHC if they receive _____ _____, _____ _____ and/or _____ _____ for the homeless grants under the federal United States Public Health Service (PHS) Act. Providers can also become FQHCs if they meet all the requirements to receive the grant but are not receiving funding. Refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section (rural) in the appropriate Part 2 provider manual.

3. **What are the differences between FQHCs and RHCs?**

   RHCs must be located in a _____ _____ that is an MUA. An FQHC must be in an MUA serving a _____ _____ _____ (MUP). However, an RHC retains its status, unlike an FQHC, even if its MUA location is later determined to no longer be rural or medically underserved.

4. **How are FQHCs and RHCs different from other Medi-Cal providers?**

   FQHCs/RHCs are reimbursed on a _____ _____. Other Medi-Cal providers are reimbursed under a Schedule of Maximum Allowances (SMAs).

5. **Do Medi-Cal service limits apply for services provided in the FQHC or RHC setting?**

   Yes. W&I Code, Sections 14132, et seq., set the scope of coverage of Medi-Cal services. In addition, FQHC/RHC services are subject to the _____ State Plan _____ _____ as services provided outside the FQHC setting. Refer to W&I Code, Sections 14132, et seq., and CCR, Title 22.

6. **Are there limitations to psychology services?**

   _____. Psychology services are no longer limited to a maximum of _____ per calendar month. Refer to the December 2013 bulletin 471 article.

Answer Key: 1) outpatient primary care clinic; 2) migrant health, community health, health care; 3) rural area, medically underserved population; 4) PPS rate; 5) same, frequency limits; 6) Yes, two

FAQs (Continued)

7. **Are services provided in a patient's home covered FQHC services?**

   Under certain _____, FQHC services may be covered when provided in a patient's home.

8. **Are laboratory and X-ray costs allowable costs to be included in FQHCs cost reports? Under what circumstances?**

   _____. The following criteria must be met:

   - The service complies with the Medicare RHC and FQHC Manual, Chapter IV (HCFA Pub 27).
   - The service is available to all _____ _____, as required by federal law unless exempt from this requirement.

   NOTE
   Laboratory services provided by an outside or independent laboratory are not covered FQHC services.

9.

   a. **Are mental health office visits for the sole purpose of monitoring or changing drug prescriptions included in the cost of covered services?**
      _____.

   b. **Can these visits be counted as a face-to-face visit?**
      Brief mental health office encounters are _____ in the covered services and are apportioned to the Medi-Cal program based on FQHC cost report statistics. These visits _____ _____ fall within the federal definition of a face-to-face visit.

10. **Are the Medi-Cal benefit limits applicable to psychology and psychiatric services?**

    _____. Medi-Cal utilization controls have been specified for psychology and psychiatric services.

11. **Are all clinical social workers and clinical psychologists required to be licensed to provide FQHC services?**

    _____. FQHC clinic staff must be licensed, certified or registered personnel in accordance with applicable state and local laws.

12. **Do authorization (TAR) requirements apply to an FQHC/RHC?**

    _____. DHCS _____ _____ require TARs for services provided by FQHCs. However, DHCS requires providers to maintain medical justification necessary for TAR approval if DHCS elects to review the documentation.

Answer Key: 7) circumstances; 8) Yes, Medi-Cal recipients; 9a) No;9b) included, do not ;10) No; 11) Yes; 12) No, does not

Top Ten Denials for RHC, FQHC and IHS/MOA Providers

Denial #	RAD Code	Message
1	0250	Quantity exceeds allowed for per-visit codes, or a claim with the same date of service and the same per-visit code was found in history. Medical justification required.
2	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
3	0626	Non-emergency related services are not payable for aid code 55 recipients.
4	0049	Provider billing error. Claim line is invalid. Verify line charge, procedure code and other line information.
5	0314	Recipient is not eligible for the month of service billed.
6	0248	Rural Health Clinics must bill per-visit codes only.
7	0008	The provider of service is not eligible for the type of services billed.
8	0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
9	0311	Recipient is not eligible for Medi-Cal benefits without complete denial coverage statement from PHP/HMO (Prepaid Health Plan/Health Maintenance Organization).
10	0036	RTD (*Resubmission Turnaround Document*) was either not returned or was returned uncorrected; therefore, your claim is formally denied.

Acronyms

A&I	Audits and Investigations
ADHC	Adult Day Health Care
AEVS	Automated Eligibility Verification System
BIC	Benefits Identification Card
CCR	California Code of Regulations
CCS	California Children's Services
CFR	Code of Federal Regulations
CHDP	Child Health and Disability Prevention
CHIP	Children's Health Insurance Program
CIN	Client Index Number
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
FQHC	Federally Qualified Health Center
FRADS	Federally Required Adult Dental Services
HCP	Health Care Plan
HMO	Health Maintenance Organization
IHS/MOA	Indian Health Services, Memorandum of Agreement
LCSW	Licensed Clinical Social Worker
LTC	Long Term Care
MFCC	Marriage, Family and Child Counselor
MRMIB	Managed Risk Medical Insurance Board
MRN	Medical Remittance Notice
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NPI	National Provider Identifier
OBRA	Omnibus Budget Reconciliation Act
PCC	Primary Care Clinic

PHP	Prepaid Health Plan
PHS	Public Health Service
POE	Proof of Eligibility
POS	Point of Service
PPS	Prospective Payment System
RA	Remittance Advice
RAD	Remittance Advice Details
RHC	Rural Health Clinic
RTD	Resubmission Turnaround Document
SMA	Schedule of Maximum Allowance
SOC	Share of Cost
TAR	Treatment Authorization Request
TCN	TAR Control Number
THP	Tribal Health Program
W&I	Welfare and Institutions