



# **West Virginia Children's Health Insurance Program**

## **Billing Instruction Manual for Federally Qualified Health Centers (FQHC's) and Rural Health Centers (RHC's) Under a Prospective Payment System**

**December 2011**

## **Introduction**

The West Virginia Children's Health Insurance Program (WVCHIP) provides quality health insurance coverage to uninsured children in families whose income disqualifies them from coverage available through the Medicaid Program, but is less than or equal to 300% of the current Federal Poverty Level (FPL). Benefits include coverage for medical and behavioral health services, dental, vision, and drug coverage. WVCHIP is a "separate" CHIP and is operated independently of the state's Medicaid Program.

Section 503 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandated that "separate" CHIP programs pay Federally Qualified Health Centers (FQHC), FQHC "look-alikes", and Rural Health Clinics (RHC) under a prospective payment system (PPS). This PPS provides for per-visit rates (encounter rates) based on each center's reasonable costs. Policy regarding WVCHIP's PPS is included in "**West Virginia Children's Health Insurance Program, FQHC/RHC Prospective Payment System (PPS), System Overview and Policies**" and is located at [www.chip.wv.gov](http://www.chip.wv.gov). This document provides the billing instructions for FQHC and RHC to follow.

### **Provider Participation Requirements:**

In order to receive reimbursement under the WVCHIP PPS, clinics must be certified by the Centers for Medicare and Medicaid Services (CMS) as either FQHC or RHC, or a FQHC "look-alike". This certification must be provided to WVCHIP's Third Party Administrator (TPA), as well as State licensure documentation.

### **Member Eligibility:**

Eligibility for WVCHIP is determined by the West Virginia Department of Health and Human Resources (WVDHHR), Bureau for Children and Families, in county offices located throughout the state. Once determined eligible, children are enrolled for continuous 12-months of coverage. Coverage under WVCHIP ends for the following reasons:

- 1) The 12-month period of ends and the parent/guardian does not reapply for benefits; or
- 2) The child reaches the maximum age of 19 (coverage ends the last day of the month of the child's 19<sup>th</sup> birthday); or
- 3) The child moves out-of-state; or
- 4) The child dies; or
- 5) The child is enrolled in Medicaid; or
- 6) The child obtains individual or group health insurance coverage; or
- 7) The child becomes eligible for a state group health plan (PEIA); or
- 8) The child was approved in error and is not currently eligible; or
- 9) The parent/guardian of a child enrolled in WVCHIP PREMIUM fails to pay the monthly premium by the due date.

## **Covered Services:**

Benefits and services provided to WVCHIP members are outlined in the WVCHIP Summary Plan Description (SPD), which is located at [www.chip.wv.gov](http://www.chip.wv.gov) . The SPD lists the services covered and not-covered by the plan, precertification and prior approval requirements, member cost-sharing, and appeal processes available to both members and providers. The SPD is mailed to families of enrolled children each July, as well as upon enrollment during the year, and is also located on the website noted above.

Please note that FQHC and RHC are unique only in the methodology by which they are paid for encounter-eligible services, NOT by the scope of coverage for which they are paid. WVCHIP coverage rules and benefit limits apply.

## **Payment for Services:**

The patient visit, or “encounter”, is the fundamental element of the PPS reimbursement structure, with the exception of services that are carved-out of the PPS rate. Services that do not constitute a billable encounter are those services that do not meet the definition of an “encounter” .

WVCHIP encounter rates apply to medical, behavioral health, and dental services provided by in FQHC or RHC settings. Please refer to the **“WVCHIP, FQHC/RHC Prospective Payment System (PPS): System Overview and Policies”** document located at [www.chip.wv.gov](http://www.chip.wv.gov) for more information.

An encounter is a face-to-face visit between a WVCHIP member and a center/clinic practitioner as listed below:

- Physician
- Physician assistant
- Nurse practitioner
- Advanced practice registered nurse
- Registered nurse
- Visiting nurse
- Psychiatrist
- Clinical psychologist
- Clinical social worker
- Licensed professional counselor
- Dentist
- Dental Hygienist
- Chiropractor
- Podiatrist
- Ophthalmologist
- Optometrist
- Physical, Occupational, Respiratory, or Speech therapist
- Audiologist

Encounter rates include payments for supplies or services related to the patient visit, including supplies or services considered “incident – to” the professional service provided during the encounter. “Incident-to” services are defined as services and supplies that are an incidental but integral part of the service, commonly furnished in a physician’s office, commonly rendered without charge or included in the bill, supplies defined within the procedure code definition, furnished under the supervision of the health care professional, and rendered by a staff member of the center or clinic. “Incident – to” services are typically not recognized as encounters and are not separately reimbursable. These services include blood pressure measurement, blood draws for lab services, height/weight measurement, medical supplies or disposable medical products, sample medications not provided through a prescription, drugs or biological that cannot be self-administered, obtaining blood or urine samples, and any service or supply considered “incident-to” a professional service, or services provided by practitioners that do not provide face-to-face encounters. Appendix I lists service codes and procedures that are included in the encounter rate and also those considered “incident-to” codes and are not separately payable. The list is not all-inclusive.

### **Pass-Through Services**

Certain types of non-encounter services are excluded from the encounter rates and are reimbursed under the WVCHIP fee-schedule. These services are laboratory and radiology services, prescription drugs, and durable medical equipment and prosthetic devices. Prescription drugs are excluded to the extent that the center or clinic has an in-house pharmacy that bills for pharmacy services separately through the point-of-sale. For centers or clinics without an in-house pharmacy, the costs of the dispensing physicians are included in the encounter rate. Also, except for “incident-to” services that are included in the PPS rate, any service provided by the center or clinic that does not meet the definition of a billable encounter is a “pass-through” service.

### **Places-of-Service Eligible for Payment of the Encounter Rate**

Encounters are recognized for payment when they take place in the following settings:

<b>Place of Service Code</b>	<b>Place of Service Description</b>
03	School (school-based location must be FQHC/RHC certified)
11	Office
12	Home
31	Skilled Nursing Facility
32	Nursing Facility
50	FQHC
72	RHC

Providers must bill the appropriate place of service code on each claim in order to receive the encounter rate.

### **Places-of-Service Excluded from Encounter Rates**

Services not provided in an FQHC or RHC setting are not eligible for reimbursement under the encounter rate. Examples are services provided by clinic practitioners to WVCHIP members in

inpatient or outpatient hospital settings. If these services are provided and are a covered benefit under the WVCHIP, they may be billed and paid outside the PPS encounter rate using WVCHIP fee schedules. Additionally, because under Medicare cost reporting guidelines providers are not to include on the cost report such services rendered in non- FQHC/RHC settings, these costs are not included in the PPS encounter rate.

### **Encounter Restrictions and Limitations**

Encounters with more than one eligible practitioner and multiple encounters with the same eligible practitioner that take place on the same date, at a single location, and that have the same diagnosis constitute a single encounter. The following two conditions are recognized for payment of more than one encounter rate on the same day:

- After the first encounter, the member suffers a different illness or injury requiring additional diagnosis or treatment; and
- The patient has a medical visit, a behavioral health visit, or a dental visit on the same day.

The medical necessity of multiple encounters must be clearly documented in the medical record. Providers must exercise caution when billing for multiple encounters on the same day, and such instances are subject to post-payment review to determine the validity and appropriateness of multiple encounters. Providers may not inappropriately generate multiple encounters by unbundling services that are routinely provided together during a single visit or scheduling multiple patient visits for services that could be performed at a single visit.

### **How Do I Bill for Encounter-Eligible Services?**

FQHC and RHC may submit claims for medical or behavioral health services provided to WVCHIP members on paper UB04 or CMS 1500 forms or electronic 837P claim forms. Dental claims should be filed using the 2006 ADA claim form. Claims must be filed within six (6) months from the date of service. The encounter code T1015 must be listed in addition to the related fee-for-service procedure codes in order for the claim to process. Total charges for the encounter should be billed with code T1015, except for charges associated with “pass-through” codes. Centers may also list an appropriate modifier with the T1015 code to distinguish the type of visit. The list of appropriate modifiers is in Appendix III. Codes listed on the claim that are included in the encounter should be billed with zero charges.

Claims with codes qualified for the encounter payments but no corresponding encounter code will be denied, unless the codes identify billings for “pass-through” services or supplies, which are paid at fee-schedule amounts. Billings for “pass-through” services and supplies may be billed without the encounter code listed on the claim or in addition to the encounter code listed on the claim. If listing “pass-through” codes in addition to the encounter, please include full charges for the “pass-through” services on the line with the “pass-through” code, and be sure to exclude these charges from the T1015 line.

Include only one encounter per claim. Claims with more than one encounter listed will be denied. When billing for more than one encounter per day, submit one claim for each encounter. On each claim, to indicate it is a separate encounter, enter “unrelated diagnosis” and the time of both visits in field 19 on the 1500 Claim Form or in the Comments field when billing electronically. Documentation for all encounters must be kept in the member’s file.

The following CMS-1500 Claim Form instructions relate to FQHCs:

<b>Field No.</b>	<b>Name</b>	<b>Entry</b>
24B	Place of Service	Enter one of the valid place of service codes outlined in these instructions
24J	Rendering Provider ID#	Enter the service-specific taxonomy code (upper field. NPI (lower field)
33B	Physician’s or Supplier’s Billing Name, Address, Zip Code and Phone #.	Enter your billing NPI and FQHC taxonomy code 261QF0400X or RHC taxonomy code 261QR1300X.

## APPENDIX I

### Services Included in Encounter Rates

Procedure codes and services listed in this appendix are those typically included within payment for an encounter. This is not an all-inclusive list. Determination of inclusion within an encounter payment for particular service or supply codes is based upon criteria outlined in the “**WVCHIP, FQHC/RHC Prospective Payment System (PPS): System Overview and Policies**” document located at [www.chip.wv.gov](http://www.chip.wv.gov) and the WVCHIP benefit.

#### Evaluation and Management Services:

99201      99211  
99202      99212  
99203      99213  
99204      99214  
99205      99215

#### Preventive Services:

99381      99391  
99382      99392  
99383      99393  
99384      99394  
99385      99395

**Surgical Services:** 10000 – 69999

**Vaccine Administration** (Note: WVCHIP purchases vaccines for members through the Vaccines for Children Program (VFC).)

**Medical Supplies:** Supplies included in the procedure code definition are included in the encounter rate

**Drugs and injectables:** J0000 – J9999

#### Medicine:

Immune Globulins, Serum or Recombinant Products: 90281- 90399

Psychiatry: 90801 – 90899

Gastroenterology: 91010 – 91299

Ophthalmology: 92002 – 92499

Otorhinolaryngologic: 92502 – 92700

Cardiovascular: 92950 – 93799

Pulmonary: 94002 – 94799

Allergy and Clinical Immunology: 95004 – 95199

Endocrinology: 95250 – 95251

Neurology and Neuromuscular Procedures: 95800 – 96020

Central Nervous System Assessments/Tests: 96101 – 96125

Health and Behavior Assessment/Intervention: 96150 – 96155

Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, And Chemotherapy and

Other Highly complex Drug or Highly Complex Biologic Agency Administration: 96360 – 96549

Physical Medicine and Rehabilitation: 97001 – 9799

Chiropractic Manipulative Treatment: 98940 – 98943

Home Health Procedures/Services: 99500 – 99602

**Dental:** Dental services and procedures defined by the American Dental Association (ADA), as covered under WVCHIP and meeting the definition of an encounter.

**APPENDIX II**  
**Pass-Through Services**

Procedure codes and services listed in this appendix are not included in the encounter rate payment and are paid according to WVCHIP fee-schedules. This is not an all-inclusive list. Determination of exclusion from an encounter payment for service or supply codes is based upon criteria outlined in the **“WVCHIP, FQHC/RHC Prospective Payment System (PPS): System Overview and Policies”** document located at [www.chip.wv.gov](http://www.chip.wv.gov) and the WVCHIP benefit.

Radiology: 70010 – 79999

Laboratory and Pathology: 80047 – 89398

Durable Medical Equipment

Prosthetic Devices

All services/supplies that do not meet the definition of an encounter or occur in settings not eligible for encounter payment.



### **Appendix III Modifiers**

The following list of modifiers may be listed on the claim with the T1015 code to distinguish the type of visit. The use of modifiers is voluntary.

- U1 Medical encounter
- U2 Dental encounter
- U3 Mental Health encounter
- U4 Physical Therapy encounter
- U5 Speech Therapy encounter
- U6 Podiatry encounter
- U7 Vision Services encounter
- U8 Chiropractic encounter