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Proposed Revisions to Medicaid Services Manual (MSM) Chapter 2900 – Federally Qualified Health Centers (FQHC) And Shadow Billing for Fee-for Service FQHC Encounters

Nevada Division of Health Care Financing and Policy (DHCFP)

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Agenda

- Introductions
- Presentation
- Comment
- Questions

Medicaid Services Manual Chapter 2900 - FQHC

Originally moved from Medicaid Services Manual (MSM), Chapter 600 on 10/1/2018. Chapter 2900 was created for FQHC policy.

The latest revision dated June 26, 2019, provided language for Partial Hospitalization Program (PHP) under Ancillary Services.

Proposed Revisions: Introduction

Added language for clarification of FQHCs role within the community as:

- Safety Net Providers
- Community Based Care
- Providers of Patient-Centered Care

Proposed Revisions: Authority

Section 2901 – Authority

- Cited correct section of the Omnibus Budget Reconciliation Act (OBRA).
- Expanded Nevada Revised Statutes (NRS) citations for licensed professional's scopes of practice.

Proposed Revisions: Policy

Section 2903 – Renamed from Health Services to Policy

- Categories of encounters.
- Used State Plan language related to multiple visits in a day (Medical, Mental/Behavioral Health, and Dental).
- Expanded policy definition for an encounter.
- Incorporated 2903.4 - Service Limitations language throughout the section for clarity and continuity.

Proposed Revisions: New Section Coverage and Limitations

Section 2903.1 - Coverage and Limitations

- Defined Medical, Mental/Behavioral Health, and Dental encounters.

Proposed Revisions: Services

- Section 2903.1 – Non-Covered Services, renumbered to 2903.2.
  - No change in policy

- Section 2903.3 – FQHC Pharmacies – Provides guidance to FQHCs that want to enroll their pharmacy to give vaccines

- Section 2903.2 – Ancillary Services, renumbered to 2903.4.
  - No change in policy

Proposed Revisions: New Section CCBHC

Section 2903.5 – FQHCs dually enrolled as a Certified Community Behavioral Health Center (CCBHC)

- Provider to develop policies concerning referrals to FQHC or CCBHC.
- Use of Service Grid and Care Coordination to avoid duplication of services and/or billing.
- Surveillance and Utilization Review (SUR) unit to monitor for duplicate billing.

Proposed Revisions: No Changes

- Section 2903.3 – Medical Necessity - Now 2903.6, no changes in policy.

- 2903.5 – Prior Authorizations – Now 2903.7, adding policy to 2903.7.C - FQHCs not contracted with a Managed Care Organization (MCO), must follow the MCOs Prior Authorization policy.

FQHC Shadow Billing.

- To be added to the Fee-for-Service Provider Type 17/181 Billing Guide.
- Future implementation of the FQHC shadow billing was announced at the July 22, 2020 FQHC Quarterly Meeting.
- Shadow billing will allow us to capture data for EPSDT reports, track utilization for future data requests or programmatic implementation.
- Shadow billing anticipated implementation date is December 29, 2020.
- DXC will provide Web Announcements and provider training.

FQHC Shadow Billing, continued…

- FQHC providers will continue to use the current Medical, Behavioral/Mental Health and Dental encounter codes.
- All utilized CPT, HCPC or CDT codes within a visit must be included on all fee-for-service claims with a Q2 modifier.
- The Q2 modifier will result in a non-pay status of the claim line; system will only pay for encounter.
- Include medical procedure codes under the medical encounter code, behavioral health procedure codes under the behavioral/mental health encounter and dental codes under the dental encounter.
- Claims submitted after the implementation date will be rejected if accompanying codes and modifier are not included on the claim. Note: date of submission of claim not date of service on the claim.

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Questions?