FQHC Technical Workgroup
February 12, 2015; 2:30 PM - 3:30 PM
AHCCCS, 701 E Jefferson, Phoenix - Gold Salmon Rooms, 3rd Floor

Attendees (Based upon sign-in Sheets)

AHCCCS
Lori Petre, Shelli Silver, Victoria Burns, Arturo Cruz, Jeanne Golden-Burke, Kim Bodary, Dave Mollenhauer

Bridgeway
Jeff Adams, Nancy Mauer

Care1st
Jessica Igneri, Tim Tejada

CPSA
Darell Dare, Eunice Rhodes, Naomi Martinez

Health Net
Bob Oetren, Bruce James

Health Choice
Mia Villa

Mercy Care
Julie Dyer

UAHP
Matthew Kingry

UHC
Deb Alix, Jeff Kearl, Susan Knobbe

PHP
Mike Flynn, Vicki Potteiger, Vincent Mexlezed

GoTo Participants: BILL, Blackshaw, Owen, I, bobbie, Bronski, Helen, Brooke Laughlin, Cathy Karson, Cheri Burian, Dan Parker, Kathlene A Semien, Kayla Caisse, Kristin Tunis, LaPlante, Kirk, Maria Sanchez, Mike Policky, Raffi Avedian, Rita, Samit P Thakur, Susan, Tia Martinez, Tricia Todaro, Vargas, David

Welcome

Lori welcomed everyone and provided key updates related to the project since out last meeting.

Everything including handouts and the meeting minutes will be posted to the website. If you see anything that isn't correct, please let us know as we want a complete and accurate record.

Lori accepted all the changes in the matrix from the last meeting and added new updates. There are two handouts for today's meeting - an updated matrix and the first draft of the billing instructions which will reflect the T1015. Lori still needs to update the document with more examples but it is ready for an initial review.

Timeline for implementation:

- Completion of Provider Registration process by FQHCs and RHCs COMPLETE– Completed
  - There was some concern about a few FQHCs which are still not registered or showing as registered. Victoria is working with provider registration on this.
- AHCCCS testing to begin internal – In Progress
- Go/no go decision for 4/1/2015 - Completed
- Update Billing manual, send claims clues/encounter key/DFSM list serve – In Progress
- AHCCCS system changes complete by – In Progress
- CAP rates to CMS by -2/15/15
- MCO and External Provider testing to begin- 02/23/15
- MCO system change complete by – In Progress
- Date AHCCCS and MCOs begin to make PPS payment (dates of service) directly to FQHCs and RHCs – 4/1/15

FQHC/RHC Q&A's Related to January 1, 2015 Changes as Tracked in the AHCCCS Matrix

Lori provided updates to the question matrix.

- Question #59: Clarified
- Question #81: Updated
- Question #82: Updated
- Question #88: Updated
- Question #92: Clarified

Question: Is Medicare going to do anything with the T Code or do they just disregard it?

Answer: Lori answered that Medicare would likely disregard it..

- Question #93: Updated
- Question #94: Updated

Lori asked that everyone please review the matrix one last time and let her know of any edits. It will then get published to the website.

Question: A question was asked modifiers.

Answer: Lori will be talking about modifiers and what needs to be placed on the T1015 but would like to discuss this further with the workgroup..

Question: We talked last week about making sure all the services are on the claim were covered before we allowed the T1015. Would there be a need to submit the encounter with all lines instead of one line?

Answer: Lori said we group them together for encounters editing/auditing as needed as we have some contractors who submit theirs together and some who submit them separately. We have to have logic that puts them together, so we can accept them either way.

T1015

Shelli said we asked that you get back to us regarding whether you or dental vendor or dental clearing house was going to have issues switching from D codes to T codes. There are only 2 FQHCs which will have an issue so they will need to file paper claims if those issues cannot be resolved.

Shelli clarified a few concerns from comments coming from the FQHC's. First was that a D coded was going to be needed which is not true. Second, someone said some payers don't like this and they want it to be a D code. Remember we didn't give you any direction that we were backing off from this as we are just investigating and looking into it. We are trying to scope the problem and the solution will be based on the scope. You either make the changes or submit a paper claim.

Someone made a comment that Dentaquest is actually checking to see if they can use a T code.

Billing Manual

Lori reviewed billing manual.

Updates to be added:

"Beginning April 1, 2015 date of service, all FQHC, FQHC-LA, and RHC will be required to bill on form 1500 or ADA form as appropriate, utilizing appropriate place of service coding (include values) and using their NPI for the FQHC or RHC as both the rendering and billing provider on the claim.

"Add paragraph about multiple visits in the same day"

Will add additional examples for:

- EPSDT Visits;
- 2 Visits on the same day with different diagnosis (both physical health) (one physical health and one behavioral health), etc…;
- 2 unique Visits on the same day with the same diagnosis;
- Maternity and surgery normally global billing situations
- Medicare and OTI primary
- No T1015 billed
- Place of service example – including invalid place of service for T1015
- Add paragraph & example T1015 with only lab or diagnostic test, etc

Lori said what she has defined right now as place of service codes allowed for the T1015 are office, outpatient hospital, independent clinic, FQHC, public health center, and rural health clinic. If there are others you can think of, please let Lori know. She sampled about 300 claims/encounters of both 1500s and dental that came in via the current FQHC process to make

sure we were accommodating the right place of service and modifiers and things that were being utilized currently in addition to our other modifiers.

The examples in this manual are very basic. If you would like other examples in here, let her know.

Question: On covered and non-covered services with the T1015, would that still be payable
Answer: Lori answered as long as you have other covered services associated with that visit.

Question: Does AHCCCS care about how our system handles this and we zero paying or denying a claim?
Answer: Lori said as long as it is clear to the provider what you are doing.

Question: You would still expect to see it on the claim though?
Answer: Lori said it depends on what you mean by non-covered. This is not to be confused with bundled services which Lori still wants. I don't expect you to pay them but she still needs them. If it is a true non-covered service like the example of dental for an adult, I wouldn't expect to see that.

Question: If it is a covered service but it is bundled, do you want it to be zero and not denied?
Answer: Lori said correct and what they do now is disallow those. It will be just like any disallowed service. Make sure you make it very clear to the provider what you have done.

ACTION ITEM: Lori will add a statement to clarify "incident to."

Question: What is the qualifier before the NPI?
Answer: Lori said you actually do use the XX.

Question: Do we use that back slash?
Answer: Yes

Question: If the length exceeds the number of characters in the first segment, do you expect us to send a 3rd and 4th segment?
Answer: Lori said yes and you can fit two in each segment and at the very bottom of pages 6 and 8, she did add a note about this. It can be repeated five times. If the name is longer than twenty characters, we can just truncate that.

Question: If we have five providers, we won't be able to tie that to what they provided?
Answer: Lori replied correct not within that claim. It is just for reporting and who is participating.

Please review this document and if you see any errors, please let Lori know. She will be sending a draft/working copy of this to the FQHCs and this group tomorrow for their review and input. It will not be posted to the webpage at this time pending at least this initial review.

Modifiers

Lori is open to recommendations. We will evaluate whether we need to add the EPSTD modifier to it to allow for that reporting or not. We need the ability to identifying the same diagnosis but two different visits on the same day. Right now both 25s and 59s are being use. Codes 76 and 77 are more surgical modifiers and probably would not fit. It was decided that 25 would be the best one to use.

Lori asked about the service limit for the T1015 code and it was decided that the daily limit would expanded to 3. If you get 4, please review for medical necessity and request an override if necessary..

ACTION ITEM: Lori will summarize the reference tables and share with the group.

Question: Since this is winding down, would this be the last meeting?

Answer: Lori is thinking we should meet one last time in a few weeks.

Next Workgroup Session

Next meeting will be scheduled in a few weeks.