



## Connecticut Medical Assistance Program

Policy Transmittal 2014-11

Provider Bulletin 2014-34

May 2014

Roderick L. Bremby, Commissioner

Effective Date: July 1, 2014

Contact: Nina Holmes @ 860 424-5486

TO: Federally Qualified Health Centers

RE: Non-FQHC Services Rendered in the Hospital and Nursing Facility

### Overview

The Department is implementing system changes which will allow enrolled FQHCs to bill on behalf of FQHC-employed physicians, advanced practice registered nurses (APRN), certified nurse midwives (CNM), physician assistants (PA), and podiatrists (all referred to as *practitioner* throughout this PB) for services provided in the hospital and nursing facility settings. This system change will be effective 7/1/2014 and apply to services reimbursed under HUSKY Health (HUSKY A, B, C, and D).

This change will also apply to services reimbursed under the Family Planning Limited Benefit and the Tuberculosis Limited Benefit programs to the extent that the service is eligible for reimbursement under the applicable limited benefit program. Please refer to PB 2012-07 and PB 2011-73 for more information on the family planning limited benefit and the TB limited benefit programs respectively.

This change is being implemented based on guidance received from the Centers for Medicare and Medicaid Services (CMS), which states that an FQHC should be permitted to bill Medicaid for services provided in the hospital and nursing home when such services are provided by an FQHC-employed practitioner to an FQHC patient. The guidance further clarifies, however, that since these services are **not** FQHC services (i.e. non-FQHC services) the reimbursement must be based on the

physician fee schedule amount and **not** the FQHC encounter rate.

Based on this guidance the Department is configuring the claims processing system in support of this initiative. Since the services billed for under this initiative are deemed non-FQHC services and the services are provided by physicians, APRNs, CNMs, PAs, and podiatrists, the Department has outlined key provisions that the FQHC and the FQHC-employed practitioner must follow.

### Enrollment

As communicated in PB 2014-25, in order for an FQHC to bill on behalf of an FQHC-employed practitioner for services rendered in a hospital or nursing home, the FQHC must enroll and obtain a separate provider ID number corresponding to the types of non-FQHC services provided. Please refer to PB 2014-25 for more information on the enrollment process.

### Policy Guidance

Please note non-FQHC services provided by physicians, APRNs, CNMs, PAs, and podiatrists in the hospital and nursing home setting are categorized as practitioner services. Given this the following regulations must be followed (as applicable) when rendering and billing for non-FQHC services:

- Sections 17b-262-337 through 17b-262-349: Regulations Concerning Physicians' Services

- Sections 17b-262-452 through 17b-262-463: Requirements for Payment of Psychiatrists' Services
- Section 17b-262-573 through 17b-262-585: Requirements for Payment of Nurse-Midwifery Services
- Section 17b-262-607 through 17b-262-618: Requirements for Payment of Nurse Practitioner Services
- Section 17b-262-619 through 17b-262-629: Requirements for Payment of Podiatrist Services

To access the regulations go to the Connecticut Medical Assistance Program (CMAP) Web site at: [www.ctdssmap.com](http://www.ctdssmap.com). From there select Publications>Provider Manuals>Chapter 7. Choose the regulation categories from the drop down box.

### **Billable Services and Fee Schedules**

Only the procedure codes identified on the non-FQHC service table are billable. Any procedure code that is not listed will deny. The Department will consider adding additional services on an annual basis (effective January 1<sup>st</sup> of each year); however the FQHCs must submit a request in writing to the Department including a clinical justification for the addition. Please submit the request to the Medicaid Medical Director by September 30<sup>th</sup> of the preceding year.

The non-FQHC service table may be located by going to the Connecticut Medical Assistance Program Web site: [www.ctdssmap.com](http://www.ctdssmap.com). From this Web page, go to "Provider", then to "Provider Fee Schedule Download", then click the link labeled "Fee Schedule Instructions" and do a "find" on non-FQHC service table. The fee schedule instruction document contains 3 tables that list the billable procedure codes.

Please note when services are provided by an APRN or CNM these services must be billed with modifier SA (Nurse Practitioner) or SB (Nurse Midwife) as appropriate.

Consistent with current Medicaid policy when a service is provided by an APRN, CNM, PA or podiatrist the reimbursement is set at 90% of the physician fee on file.

Payment for non-FQHC services will be based on the Medicaid Physician Office and Outpatient or the Physician Surgical fee schedules. The fee schedules can be accessed and downloaded by going to the Connecticut Medical Assistance Program Web site: [www.ctdssmap.com](http://www.ctdssmap.com). From this Web page, go to "Provider", then to "Provider Fee Schedule Download".

Note that the physician office and outpatient and surgical fee schedules will have a footer that points to the fee schedule instructions. Only the procedure codes identified on the non-FQHC service table are billable.

### **Prior Authorization for Behavioral Health Services**

Consistent with current policy there are certain medical and behavioral health services which will require prior authorization.

Prior authorization is required for physician or APRN behavioral health services provided in place of service (POS) 31 - skilled nursing and POS 32 - nursing facilities. For more information about prior authorization for these or any **behavioral health service** providers should contact CT Behavioral Health Partnership (BHP) at 1-877-552-8247.

*Please note prior authorization is **not** required for hospital inpatient psychiatric services provided by a physician or APRN.*

### **Prior Authorization for Medical Services**

Prior authorization is required for certain physician, APRN, PA, and podiatrist medical services provided in an outpatient hospital, and ambulatory surgery center (POS 22 and 24). Providers may access the Outpatient Prior Authorization Request Form for medical services on the HUSKY Health website: [www.huskyhealth.com](http://www.huskyhealth.com). From the home page

select “Providers”. From the provider page select “Provider Bulletins, Updates and Forms”. The Outpatient Prior Authorization Request Form is located on the right side of the screen. Forms should be faxed to CHNCT at (203) 265-3994.

For questions regarding the prior authorization process for **medical services**, please contact CHNCT at 1-800-440-5071, Monday through Friday between the hours of 8:00 a.m. and 7:00 p.m.

The FQHC will be required to obtain authorization for these services **PRIOR** to rendering the services. Failure to obtain prior authorization will result in a denial of the claim. The Prior Authorization must be obtained under the new FQHC number for non-FQHC services. For a list of services requiring Prior Authorization please access the applicable fee schedule. If a service requires prior authorization it will be noted.

### **Non-FQHC Claims Submission**

All non-FQHC services should include one of the appropriate procedure code(s) outlined on the non-FQHC Service Table and must not include T1015. All claims must be submitted under the appropriate provider ID for non-FQHC services. Please note claims will only pay when submitted with one of the following Place of Service (POS) codes:

- 21 – Inpatient Hospital
- 22 – Outpatient Hospital
- 23 – Emergency Department
- 24 – Free-standing Ambulatory Center
- 25 – Birthing Center
- 31 – Skilled Nursing Facility
- 32 – Nursing Facility

Claims submitted with any other POS code value will deny.

### **Documentation**

As outlined in the Medicaid regulations a specific record must be maintained for all services rendered. This means that the

hospital and nursing home services rendered must meet all of the requirements of the applicable provider regulation. Please note since the hospital and nursing home services are provided to an established FQHC patient, there does not need to be a separate medical record for the FQHC and the non-FQHC service documentation.

### **Previously Denied non-FQHC Services**

FQHCs will have the opportunity to re-submit previously denied claims between July 1, 2014 and December 31, 2014. The FQHC must first successfully complete the enrollment process to obtain their new provider ID number. Once enrolled the claims for non-FQHC services with dates of service 1/1/2012 – 06/30/2014 which have previously denied with **POS 21 (inpatient)** can be re-billed under the new provider number. The claims can be re-submitted electronically and the department will implement a measure (until December 31, 2014) to allow claims to bypass the timely filing edit.

Please note if claims previously submitted denied for reasons other than the restriction for POS 21, the claim will continue to deny.

Since the previously implemented POS restriction was specific to inpatient claims, only claims with POS 21 should be re-submitted. FQHCs should **not** re-submit any previously paid claim with POS 21 including claims previously paid under a separate physician, physician group, APRN, or CNM provider ID number.

For questions about billing or if further assistance is needed to access the fee schedule on the Connecticut Medical Assistance Program Web site, please contact the HP Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

**Posting Instructions:** Policy transmittals can be downloaded from the Connecticut Medical

Assistance Program Web site at  
[www.ctdssmap.com](http://www.ctdssmap.com).

**Distribution:** This policy transmittal is being distributed to holders of the Connecticut Medical Assistance Program Provider Manual by HP Enterprise Services.

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**Date Issued:** May 2014.