Federally Qualified Health Centers (FQHC's), FQHC Look-A-Likes (LAL's), and Rural Health Clinics-Non Hospital Based (RHC's-NHB)

Provider Manual
Volume II

January 1, 2018

New Hampshire
Medicaid

Table of Contents

Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date. This date is also included in the text box located on the left margin where the content change was updated.
Section/Sub-Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, Control Memo, etc.).

Date Change to Manual	Effective Date	Section/Sub-Section	Change Description	Reason	Related Communication
12/1/2017	1/1/18		Rebrand Document	Remove actual name of fiscal agent; replace with "fiscal agent"	
12/1/2017	1/1/18	3-Covered Services/Other Ambulatory	Added SUD services	Updated to reflect addition of SUD as new service (He-W 513)	12/1/2017 provider bulletin
12/1/2017	1/1/18	11-Payment/FFS Reimbursement	Explanation of SUD FFS vs encounter	Clarification	12/1/2017 provider bulletin
12/1/2017	1/1/18	12-Claims/Medical Services Encounter Behavioral Health Encounter	Explanation of SUD Medication Assisted Treatment (MAT) billing and codes Missing BH encounter code added	Clarification to match appendix	12/1/2017 provider bulletin
12/1/2017	1/1/18	Appendix I-procedure codes	Updated to include those updated in MMIS; Added new SUD H codes	Updates and addition of SUD Services	12/1/2017 provider bulletin

Date Change to Manual	Effective Date	Section/Sub-Section	Change Description	Reason	Related Communication

1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals includes two volumes that must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The Appendices section encompasses a wide range of supplemental materials such as Fee Schedules, Contact Information, Provider Type List, Sample Forms and Instructions, as well as other general information.

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through specific policies applicable to the provider type.

Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for participating health care providers, their staff, and provider-designated billing agents.

These manuals are ***not*** designed for use by NH Medicaid members (hereinafter referred to as members).

Provider Accountability

Participating providers should maintain both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

Document Disclaimer/Policy Interpretation

It is our intention that the provider billing manuals, as well as the information furnished to providers by the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

Notifications & Updates

Providers are notified of NH Medicaid program changes and any other changes applicable to participating providers through several types of media including postings on the Medicaid Management Information Systems (MMIS) portal, provider bulletins, provider notices, memos, letters, web site updates, newsletters and/or updated pages to the General Billing Manual – Volume I and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their service providers, billing agents and staff.

Billing manual updates are distributed jointed by the Department and the fiscal agent. Providers receive notification of manual updates through a message sent to each provider's message center inbox via the web or email blast.

Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit. See the Appendix for specific contact information.

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

Providers of NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be a participating provider. There are also ongoing responsibilities that participating providers must meet, such as verification of member eligibility and other insurance.

Eligibility to Enroll as an FQHC/FQHC-LAL/RHC

The Department and/or its associated organizations approve provider enrollment. The Department's fiscal agent, upon approval of the application, sends a notification letter to the provider. It is the responsibility of the provider to review the other provider manuals in conjunction with this one to form a complete understanding of the services, rules and regulations governing the Medicaid program.

To participate in the NH Medicaid program as a Federally Qualified Health Center (FQHC), FQHC Look-A-Like (LAL) or Rural Health Clinic (RHC) (non-hospital based), an entity must:

1. Be composed of licensed NH practitioners who are enrolled as individual provider types applicable to one's practice in NH Medicaid and who must be affiliated in the Medicaid Management Information System (MMIS) as a performing provider of the FQHC, FQHC-LAL, or RHC;
2. Furnish FQHC/FQHC-LAL/RHC services via practitioners authorized to provide these services, i.e., physicians (all specialties) (to include physician assistants under the supervision and direction of a physician in accordance with NH RSA 328-D:1), nurse practitioners, certified nurse midwives, clinical psychologists, clinical social workers, and visiting nurses;
3. Be certified to participate in Medicare as an FQHC/FQHC-LAL/RHC provider;
4. Provide medical care on an outpatient basis;
5. Be appropriately enrolled as a FQHC/FQHC-LAL/RHC group in NH Medicaid; and
6. Request and obtain service authorization from NH Medicaid before providing services that require service authorization.

The Department does not monitor provider compliance with scope of law or practice related to provider licensure or certification. It is the responsibility of providers to follow the laws associated with their licensure/certification.

NH Medicaid recognizes the following health clinics

- Federally Qualified Health Centers (FQHC) funded under Section 330 of the Public Health Service (PHS) Act and certified by CMS;
- FQHC "Look-A-Likes" (FQHC-LALs), that have been identified by Health Resource and Services Administration (HRSA) and certified by CMS as meeting the definition of "Health Center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330;
- Rural Health Clinics funded under Section 1905 of the Social Security Act.
- If Medicare enrolls sites individually then they need to be enrolled the same way in NH Medicaid.

Requests for Rate Changes Due to a Change of Scope in Service

A change of scope in service is recognized by the Department when there is a change in the type, intensity, duration and/or amount of services as a result of the following:

1. An increase of scope in service could result from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved RHC-non-hospital based (NHB), FQHC, or FQHC-LAL benefits that no current professional staff is licensed to perform.

2. A decrease of scope in service could result when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

An increase or decrease of scope in service does not necessarily result from any of the following (although some of these changes may occur in conjunction with a change of scope in service):

- an increase, decrease or change in number of staff working at the clinic except as noted above
- an increase, decrease or change in office hours
- an increase, decrease or change in office space or location
- the addition of a new site that provides the same set of services
- an increase, decrease or change in equipment or supplies
- an increase, decrease or change in the number or type of patients served

RHC-NHB's, FQHC's and FQHC-LAL's may request a change of scope in service once a year for implementation on July 1. This will be concurrent with the effective date of the increase to the encounter rate. RHC-NHB's, FQHC's, and FQHC-LAL's are required to submit requests in writing no later than March 31 in order to be effective July 1. The Department will review and analyze all requests to ensure compliance with the Medicare FQHC/FQHC-LAL/RHC regulations relative to a change of scope in service.

1. All requests should be submitted in writing to the Department by the RHC-NHB, FQHC, or FQHC-LAL and should include:

    - a detailed explanation of each change of scope in services provided by the RHC-NHB, FQHC, or FQHC-LAL delineating how services were provided both before and after the change;
    - the effective date of each change of scope in services;
    - the Medicaid visits and total visits associated with each change of scope in services;
    - the total number of visits for all sites for the same time period that the RHC-NHB, FQHC, or FQHC-LAL submits the incremental costs;
    - the incremental increase or decrease in costs by expense category for each change of scope in services; and
    - the cumulative per visit dollar amount of the PPS or APM rate adjustment requested.

2. All requests should include, at a minimum, a detailed worksheet that delineates the total incremental difference in costs for each of the categories and subcategories of expenses associated with the change of scope in service.

3. A change in costs alone in and of itself will not be considered a change of scope in service unless it is a CMS approved change of scope in service (proof of CMS approval must be supplied) and all of the following apply:

- the increase or decrease in cost is attributable to an increase or decrease of the scope in the services defined above;
- the cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413;
- the change of scope in services is a change in the type, intensity, duration, or amount of services, or any combination thereof; and
- the net change in costs in the RHC-NHB, FQHC, or FQHC-LAL's must meet a minimum threshold of 5%.

The RHC-NHB's, FQHC's, and FQHC-LAL's shall submit supporting documentation for each amount included in the categories of expenses for both the prior period and the period where there is a change of scope in services following Medicare reasonable cost principles.

The Department will review the documentation submitted by the RHC-NHB's, FQHC's, and FQHC-LAL's and will notify them as to whether the rate adjustment is approved.

The Department reserves the right to adjust the encounter rate for any change of scope in service that comes to its attention.

The following formula will be used by DHHS to determine the new rate:

$$\mathbf{NR = \frac{(R \times PV) + C}{(PV + CV)}}$$

Where:
"NR" represents the new reimbursement rate adjusted for the increase/decrease of the scope in service;
"R" represents the present Medicaid rate;
"PV" represents the present number of total visits, which is the total number of visits for the RHC-NHB, FQHC, or FQHC-LAL during the 12-month time period prior to the change of scope in service;
"C" represents the expected change in costs due to the change of scope in service; and
"CV" represents the expected change in the number of visits due to the change of scope in service

Example:

Assume the provider notified the department in writing of a change of scope in service offered prior to the July 1 implementation and the provider submitted the documentation and information necessary for the Department to make a determination. In addition, assume the RHC-NHB, FQHC, or FQHC-LAL has a present Medicaid reimbursement rate of $100 per visit with 10,000 visits per year.

A new professional staff member is added to provide services with 1,000 additional visits per year expected at an increase in cost of $140,000.

$$\textbf{NR} = \frac{\textbf{(Rx PV)+C}}{\textbf{(PV+CV)}}$$

$$\textbf{NR} = \frac{\textbf{(\$100 x 10,000) + \$ 140,000}}{(10{,}000 + 1{,}000)}$$

$$\textbf{NR} = \frac{\textbf{\$1,140,000}}{\textbf{11,000}}$$

NR= $103.64

3. Covered Services & Requirements

Services performed by FQHC's and FQHC-LAL's and covered by NH Medicaid are those defined in Section 1905(a)(2)(C) of the Social Security Act. Services performed by RHC's (NHB) are those defined in Section 1905(a)(2)(B) of the Social Security Act.

FQHC/FQHC-LAL/RHCs enrolled in NH Medicaid are authorized to perform services within the specific scope of services approved for the facility by the Health Resources and Services Administration (HRSA) and that are included as a covered service in the NH Title XIX State Plan.

FQHC/FQHC-LAL/RHC covered services can be categorized as encounter and incidental services, and other ambulatory services.

Encounter and Incidental Services

FQHC/FQHC-LAL/RHC encounter and incidental services generally include:

- Physician services (to include physician assistants under the supervision and direction of a physician in accordance with NH RSA 328-D:1, nurse practitioners, certified nurse midwives, clinical psychologists, clinical social workers, visiting nurses;
- Services and supplies furnished as "incident to" professional services furnished by a physician (to include a physician assistant under the supervision and direction of the physician), nurse practitioner or certified nurse midwife; and, for visiting nurse care, related medical supplies, other than drugs and biologicals;

Services and supplies "incident to" the professional services of health care practitioners are those commonly furnished in connection with these professional services, generally furnished in a practitioner's office, and ordinarily rendered without charge, or included in the practice bill such as ordinary medications, and other services and supplies used in patient primary care services. "Incident to" services must be furnished by a clinic employee and must be furnished under the direct, personal supervision of the health care practitioner, meaning that the health care practitioner must be physically present in the building and immediately available for consultation.

Other Ambulatory Services

Other ambulatory services are also covered as FQHC/FQHC-LAL/RHC services. These include non-primary care services, such as dental services and pharmaceuticals, and all other services covered under the NH Title XIX State Plan. These services are covered according to the applicable descriptions and service limits described for each individual service in the Title XIX State Plan, the applicable departmental administrative rules, and in the applicable Provider Billing Manuals – Volume II. With the exception of behavioral health visits which are paid a separate encounter rate, other ambulatory services are reimbursed according to the Medicaid fee schedule as described in the Title XIX State Plan and applicable provider billing manuals, as these services are not included in the encounter rate. Examples of other ambulatory services include:

- Inpatient and outpatient hospital services
- Radiology services
- Pharmacy services
- Vision services (other than routine screenings)
- Dental services
- Podiatry services
- Hearing services (other than routine screenings)
- Non-routine laboratory services
- Family planning devices such as implants and IUD's
- Occupational, speech, and physical therapy services
- Substance Use Disorder (SUD) Treatment and Recovery Support Services
- Medical transportation services
- Vaccine administration for adults and children if not part of or incidental to an encounter
- Actual vaccine for adults age 19 and over regardless of whether the administration of such vaccine is part of the encounter or reimbursed separately
- Behavioral health/psychotherapy services

See the "Payment Policies" and "Claims" Sections of this billing manual for information on how encounter and ambulatory services are reimbursed.

4. Service Limits

Only the "other ambulatory services" provided by FQHC/FQHC-LAL/RHC's are subject to service limits. Service limits for other ambulatory services are the same limits that are applicable to the individual ambulatory services as described in the various departmental administrative rules and Provider Specific Billing Manuals – Volume II.

Encounter Limits

An encounter is comprised of all recipient visits with more than one health care practitioner or multiple visits with the same health care practitioner which take place on the same day and at a single location, for the same diagnosis or treatment. A recipient may have one medical and one behavioral encounter on the same day.

Providers may submit only one medical encounter and one behavioral health encounter per date of service unless a service authorization has been approved for two specific exceptions as follows:

1) Subsequent to the first encounter, the recipient suffers an illness or injury with a different diagnosis; or
2) Subsequent to the first encounter, the patient received a different treatment at a different time of the same day

5. Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type, such as those for which there is no medical need, but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the "Non-Covered Services" section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, in writing, **prior to** delivery of the service, that it is non-covered by NH Medicaid, and that, should the member still choose to receive the service, the member will be responsible for payment for the service. If this occurs, the Department recommends that the provider maintain in their files a statement signed and dated by the member that indicates that s/he understands that the service is non-covered and that s/he agrees to pay for it.

FQHC/FQHC-LAL/RHC providers should particularly note that medical nutrition therapy/diabetes education are not stand-alone services under the NH Title XIX State Plan and, therefore, will not be paid as a separate encounter payment amount but through the established medical encounter rate.

6. Service Authorizations

A service authorization (SA), also known as a Prior Authorization (PA), is an advance request for authorization of payment for a specific item or service.

Medical and behavioral encounters in and of themselves are not subject to service authorizations. Service authorizations are applicable to "Other Ambulatory Services". Please see the appropriate Provider Billing Manual – Volume II for service authorization requirements for each individual service.

A service authorization does not guarantee payment. To ensure payment, providers must verify the following before providing a service:

- The member is eligible on the date(s) of service;
- The performing and billing providers are actively enrolled providers on the date(s) of service; and
- The HCFA Common Procedure Coding System (HCPC) or Current Procedural Terminology (CPT) procedure code(s) and billing modifier(s) are active codes and valid combinations for billing under NH Medicaid.

Please note that multiple encounters in the same day may require a service authorization as noted below. See the "Service Limits" Section (4) and the "Payment Policies" Section (11).

Providers may submit only one medical encounter and one behavioral health encounter per date of service unless a service authorization has been approved for two specific exceptions as follows:

1) Subsequent to the first encounter, the recipient suffers an illness or injury with a different diagnosis; or
2) Subsequent to the first encounter, the patient received a different treatment at a different time of the same day

Requesting Service Authorization to Exceed the Encounter Limit

Service authorization requests should be submitted on the Form 272E, "Request for Prior Authorization in Excess of Service Limits," which is located on the MMIS Health Enterprise Portal web site at www.nhmmis.nh.gov, and forwarded to the Department's service authorization agent as per the instructions on the form.

Approval or Denial of Service Authorization Requests

Service authorizations requested in accordance with all of the criteria shall be approved by the Department if the Department determines that the requested additional services meet the definition of medical necessity or that coverage is supported by clinical documentation provided.

If the Department approves the SA request, a notification of the approval will be generated by the fiscal agent.

When a service authorization request is denied, written notice of the denial is mailed to the member, and a copy of the denial is faxed to the ordering practitioner to include the following:

- Reason for the denial and why criteria was not met;
- Information on how the member can file an appeal; and
- Information that a denial may be appealed by the member within 30 calendar days from the date the denial was issued.

7. Documentation

FQHC/FQHC-LAL/RHC providers must maintain supporting documentation for each service for which a claim has been submitted to NH Medicaid for reimbursement. Please see the "Record Keeping" section of the General Billing Manual - Volume I, for documentation requirements.

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer.

8. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse. These utilization review activities are required and carried out in accordance with Federal regulations at 42 CFR 455 and 42 CFR 456, and they are done to ensure that accurate and proper reimbursement has been made, for care, services and/or supplies that have been provided to a member, and for which a provider has received payment.

Utilization review activities may be conducted prior to payment, following payment, or both. These activities include, but are not limited to, conducting provider reviews. These reviews may be selected at random, generated from member complaints, other providers, anonymous calls, or from the SURS reporting system.

There are various outcomes that may result from Program Integrity review activities. They include, but are not limited to:

- Recovery of erroneous and improper provider payments;
- Provider education regarding appropriate documentation to support the submission and payment of claims;
- Ensuring that the provider has developed a corrective action plan based on the findings of the review. This includes conducting follow-up reviews to verify that the provider is complying with the corrective action plan, and continues to provide and bill for services provided to members, in accordance with the rules and regulations governing the NH Medicaid Program;
- Potential referral to appropriate legal authorities – including the NH Medicaid Fraud Control Unit (MFCU) and the Federal Office of Inspector General (OIG);
- Potential termination from the NH Medicaid Program; or
- Other administrative actions.

If a provider is found to have abused the NH Medicaid Program requirements, the provider may be restricted, through suspension or otherwise, from participating in the NH Medicaid Program for a reasonable period of time. In addition, the provider may also have their claims placed on a prepayment pend or hold status for additional review by the Program Integrity Unit.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume 1.

9. Adverse Actions

The Department may take an adverse action due to a provider's non-compliance with Federal regulations, State laws, or Department rules, policies or procedures. See the "Adverse Actions" Section of the General Billing Manual – Volume I regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

10. Medicare/Third Party Liability (TPL)

Under federal law, the Medicaid Program is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for Medicaid only services and claims for prenatal care of pregnant women or claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire). Additional information on exclusions is outlined in this section or in the General Billing Manual – Volume 1. Providers who receive payment in full from a third party are not required to file zero-payment claims with the NH Medicaid Program.

A provider must first submit a claim to the third party within the third party's time limitations. If a third party or primary insurance plan does not pay at or in excess of the applicable NH Medicaid Program reimbursement level, a provider may submit a claim to the NH Medicaid Program which is processed based on the applicable reimbursement rate minus any payment received from all other resources. Commercial health insurance coverage often provides a higher payment than does the NH Medicaid Program.

When a third party denies a claim, for any reason, a copy of the notice of denial from the third party ***must be included*** behind the claim submitted to the NH Medicaid Program. When Medicare denies a claim, a copy of the Explanation of Medicare Benefits must be attached behind the claim that is submitted. For claims not submitted on paper, the Medicare or third-party denial is considered a claim attachment.

Detailed Medicare/Third Party Liability (TPL) information is found in the General Billing Manual, including handling discrepancies in TPL resource information, correcting erroneous TPL information, and exceptions to third party filing requirements.

When a NH Medicaid member is also covered by Medicare, the provider must bill Medicare for all services before billing the NH Medicaid Program. The provider must accept assignment of Medicare benefits in order for the claim to "***cross over***" to the NH Medicaid Program. The crossover process works only for Medicare approved services; Medicare denied services and Medicare non-covered services are addressed in this section. NH Medicaid pays cross over claims only if the service is covered by NH Medicaid.

Certain services that are not covered by Medicare *may* be covered by the NH Medicaid Program for dually eligible members. Services identified in the Medicare billing manual and HCPCS coding manuals as non-covered by Medicare may be billed directly to NH Medicaid, who will determine whether or not the service is covered and can be reimbursed by NH Medicaid.

This does not apply to Qualified Medicare Beneficiary (QMB) Only members whose benefits are limited to the Medicare premiums and payment toward the Medicare deductible and coinsurance. Therefore, if Medicare does not cover the service, there is no NH Medicaid payment available for QMB members.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

11. Payment Policies

Payment for NH Medicaid services is made in accordance with rates of reimbursement established by the Department pursuant to RSA 161:4, VI (a).

Payment Methodology

There are two methods of payment for FQHCs/FQHC-LALs/RHCs:

- A fixed encounter rate for certain medical and behavioral services; and
- Fee schedules for "other ambulatory services" that are consistent with the standard NH Medicaid fee schedules for each of these services.

Encounter Rate and Incidentals Reimbursement

FQHC/FQHC-LAL/RHC services as defined in Section 1905(a)(2)(B) and (C) of the Social Security Act, as well as behavioral health services that are part of "other ambulatory services," are reimbursed at all-inclusive encounter rates. Services that are part of the encounter rate are defined in the list of codes in Appendix 1 of this manual.

In order to bill the all-inclusive encounter rate, services must be billed using the encounter code **T1015, along with one or more pertinent procedure codes that identify each specific service provided** during the visit. Claims submitted with only the medical encounter code will be denied payment.

Only one medical and one behavioral health encounter claim may be submitted per date of service unless a service authorization has been approved (see the "Service Authorizations" section) for either of the following exceptions:

1. subsequent to the first encounter, the patient suffers an illness or injury with a different diagnosis; or
2. subsequent to the first encounter, the patient received a different treatment at a different time of the same day.

The Department establishes facility-specific encounter rates for each FQHC/FQHC-LAL/RHC enrolled in NH Medicaid. Facility-specific encounter rates take into account, but are not entirely based on, the scope of services each clinic is authorized to provide as determined by CMS. NH Medicaid sets the behavioral health encounter rate equal to the medical encounter rate.

The Benefits Improvement and Protection Act of 2000 (BIPA) dramatically changed the way State Medicaid programs must calculate FQHC/FQHC-LAL/RHC encounter rates for services. Effective October 8, 2012, in accordance with this Act, NH Medicaid transitioned the FQHC/FQHC-LAL/RHC payment policies from a retrospective cost-settlement methodology to an Alternative Payment Methodology (APM) in accordance with Section 1902(bb)(6) of the Social Security Act.

The Department also calculates encounter rates using a Prospective Payment System (PPS) Methodology. Effective October 8, 2012, each provider received an encounter rate that was the greater of the APM or PPS. Only those providers that agreed in writing to the proposed APM received the proposed APM. Thereafter, annually on July 1, each provider's encounter rate will be trended forward by the MEI and adjusted for any approved change in scope of services.

Rates for newly established FQHC/FQHC-LAL/RHCs will be set as an average of the rates for similar clinics or centers in the same urban or rural settings. The effective date for such rates is the effective Medicaid enrollment date for the provider.

The APM uses the facility's FY 2011 cost-settled rates as the baseline for all subsequent years' encounter rates trending forward using the MEI (Medicare Economic Index) released November-December annually for each of those years.

The Department calculates the PPS using the formula established by BIPA 2000, using the average cost based rate per visit for provider fiscal years of 1999 and 2000 trended forward by the MEI.

Effective October 8, 2012, the greater of PPS or APM for each facility was implemented. Thereafter, each July 1 each center/clinic's encounter rate will be updated by the Medicare Economic Index (MEI). The Prospective Payment System (PPS) and Alternative Payment Methodology (APM) – are prospective in nature, cost reports or other accounting methodologies are no longer needed after the FQHC/FQHC-LAL/RHC fiscal year ending 2011.

Services considered "incidental" to a medical or behavioral encounter visit will be reimbursed as part of the service encounter rate and shall not be reimbursed separately. For example:

- Administration of vaccines;
- Routine laboratory and radiology services inherently integrated with the medical/behavioral purpose of the visit.

Fee-for-Service Reimbursement

Other ambulatory services provided by an FQHC/FQHC-LAL/RHC will be reimbursed at the Medicaid fee schedule rate for the appropriate CPT codes. For example:

- Dental
  Payment for face-to-face dental visits with a clinic's dentist or a dentist subcontracted by the FQHC/FQHC-LAL/RHC for patients who are enrolled as primary care patients of the practice will be reimbursed at the Medicaid fee schedule, subject to standard service limitations. Dental services will continue to be billed FFS by NH Medicaid enrolled providers using the appropriate CDT codes.

- Vaccine Administration
  If vaccine is not administered as part of or incidental to an encounter, the vaccine administration for both adults and children should be billed separately and will be reimbursed based on the Medicaid fee schedule. The FCHC/FQHC-LAL/RHC will not be reimbursed at the encounter rate.

- The Actual Vaccine
  The cost of the actual vaccine for adults age 19 and over will be paid at the fee for service rate, regardless of whether the administration of such vaccine is part of the encounter or reimbursed separately. The cost of the actual vaccine, if received through the Vaccine for Children (VFC) or distributed by the State/federal government, will not be reimbursed.

- Obstetric Services
  Vaginal and Cesarean section delivery services will be reimbursed at the Fee for Service rate.

- SUD Services
  With the exception of Screening, Brief Intervention, and Referral to Treatment Services (SBIRT) which is included as part of the encounter, SUD services will be reimbursed based on the Medicaid fee schedule.

12. Claims

All providers participating in NH Medicaid must submit claims to the fiscal agent in accordance with NH Medicaid guidelines. Providers should note that NH Medicaid claim completion requirements may be different than those for other payers, previous fiscal agents, or fiscal agents in other states.

Providers participating in the NH Medicaid Program are responsible for timely and accurate billing. If NH Medicaid does not pay due to billing practices of the provider which result in non-payment, the provider cannot bill the member.

Claim completion guidelines in this manual should be followed for instructions on specific fields. The NH Specific Companion Guide, which can be found at www.nhmmis.nh.gov (see provider manuals under the provider tab), should be used for electronic claim filing instructions. While field-by-field requirements are shown for paper claims; the same required data is captured through web portal claim entry and through electronic submissions to EDI. Web portal submissions feature step-by-step claim completion instructions as well as tools such as Online Help to assist providers in correct claim completion.

Regardless of the method claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

The following claim-related topics are found in the General Billing Manual – Volume I:

- Claims Submission via EDI, web portal, paper
- Claims processing – edits & audits, transaction control numbers, line item vs. header processing, claim status, remark/EOB codes
- Claim Resubmission
- Claim adjustments and voids
- Medicare cross-overs
- Claims payment
- Remittance Advice

Providers will be notified of payment or denial via a Remittance Advice, usually received in electronic format or via the web portal.

Denied claims should be resubmitted only if the reason for the denial has been corrected.

Paid claims cannot be resubmitted; resubmission of a paid claim will result in a denial as a duplicate. Paid claim corrections must be made through the adjustment process. If a paid claim has a line item denial, the individual line charge can be resubmitted.

Corrected claims and denied line items can be resubmitted only if the denial was due to erroneous, updated or missing information which is now corrected. Providers should never resubmit claims that are currently in process (suspended).

Any claim denied for failure to be submitted or resubmitted in accordance with timely filing standards will not be paid. Denied claims that have been corrected must be resubmitted as a new claims transaction on paper, via the web portal, or electronically via EDI.

Timely Filing

In accordance with federal and state requirements, all providers must submit all initial claims within one year following the earliest date of service on the claim.

Except as noted below, NH Medicaid will ***not*** pay claims that are ***not*** submitted within the one-year time frame.

Claims that are beyond the one-year filing limit, that have previously been submitted and denied, must be resubmitted on paper, along with Form 957x, "Override Request" located on the NH MMIS Health Enterprise Portal web site at www.nhmmis.nh.gov. A copy of the RA with the original billing date and the denial circled must also be attached. This resubmission ***must*** be received ***within 15 months*** of the date of service. If this time frame is not met, the claim will be denied.

The only other circumstance eligible for consideration under the one-year override process is for claims for NH Medicaid covered services for members whose NH Medicaid eligibility determination was delayed. The claim should be submitted as detailed above.

Encounter Visits and Other Ambulatory Services

FQHC/FQHC-LAL/RHCs shall submit claims for payment to the fiscal agent, on Form CMS 1500. All claims must follow proper coding nomenclature based upon the most recent version of the *CPT Standard Edition*. The list of allowable CPT codes is included in Appendix 1.

Medical Services Encounters

Claims for medical services must be billed using the encounter code T1015, along with one or more pertinent procedure codes that identify each specific service provided during the visit. If the encounter includes SUD Medication Assisted Treatment (MAT), please see below. Claims submitted with only the medical encounter code will be denied payment.

Only one medical and one behavioral encounter may be submitted per date of service, unless a service authorization has been approved. Multiple claims for medical encounter visits on a single date of service must contain different diagnosis/procedure combinations to signify the patient is receiving treatment for a different diagnosis that was acquired subsequent to the first visit.

Claims for prenatal medical visits must include the modifier "TH" added to the encounter CPT office visit code (i.e. T1015-TH plus one of the two codes 99213 or 99214) and also include one or more procedure codes that identify the specific services performed during the visit. Prenatal encounter

claims with no other procedure code will be denied payment. Specific maternity related billing codes are outlined in the Maternity Related (Pre-natal, Obstetric Delivery and Post-Partum) Services Section.

Prenatal Care at Risk for Enhanced Services (CPT code H1002) will no longer be a reimbursable service billed under T1015 as the sole service delivered that day. This CPT code will only pay if it is "bundled" with other CPT codes/services.

Prenatal and child/family health care support services (CPT code T1027 TH) is not reimbursable at the encounter rate if it is the *sole* service on the claim nor is it reimbursable at the (15 minute units) FFS rate at FQHC/FQHC-LAL/RHCs; prenatal and child health care are reimbursed at the all-inclusive encounter rate, and as such, this code will only pay if it is "bundled" with other CPT codes/services.

Family Planning Services must be billed with the appropriate family planning diagnostic and procedure codes, and with the family planning indicator checked on the claim form. Planned Parenthood codes may not be billed by FQHCs/FQHC-LAL/RHCs.

Oral health exam, application of fluoride varnish, anticipatory guidance and referral to a dental home is considered part of the medical encounter and will not be reimbursed separately.

If a SUD MAT service is rendered on the same day as a medical visit, the provider should bill T1015 for the medical encounter and then on a separate claim bill one of the below E&M codes with modifier HF for the MAT office visit.

99201
99202
99203
99204
99205
99211
99212
99213
99214
99215

Behavioral Health Services Encounters

Claims for behavioral health visits must be billed using the encounter code T1015, along with one or more pertinent procedure codes that identify each specific service provided during the visit. Claims must reflect a face–to-face visit provided by an FQHC/FQHC-LAL/RHC for patients. Claims submitted with only the encounter code will be denied payment.

The type of practitioner allowed to bill for specific codes and services are those psychotherapy providers that are allowed to enroll in the Medicaid fee for service program. Primary care providers cannot bill a behavioral health encounter. A behavioral health encounter means care provided by a Medicaid recognized psychotherapy provider.

Valid CPT codes for behavioral health encounters at an FQHC/FQHC-LAL/RHC include:

90791: Diagnostic evaluation
90792: Diagnostic evaluation with medical services
90832: 30 minute psychotherapy with patient and/or family member
90834: 45 minute psychotherapy with patient and/or family member
90837: 60 minute psychotherapy with patient and/or family member
90846: Family psychotherapy without patient present
90847: Family psychotherapy with patient present
90853 Group psychotherapy with patient present

Developmental testing (CPT codes 96110 and 96111) is considered part of the behavioral health or well-child visit and is not reimbursable at the encounter rate if it is the sole service on a claim. FQHCs/FQHC-LAL/RHCs shall list these services along with other appropriate procedure codes when submitting encounter claims for a well-child or other medical/behavioral visit. Developmental testing as the sole service should be billed as fee for service.

Cognitive testing services provided by an FQHC/FQHC-LAL/RHC for patients enrolled as a primary care patient shall only be billed as FFS using the appropriate CPT codes and are subject to service limits when not performed by a psychiatrist. The types of providers that may provide the services is limited to psychotherapy providers enrolled by the Board of Mental Health Practice, psychologists enrolled by the Board of Psychology, and psychiatrists. The codes that may be billed include:

96101: A per hour code (minimum of 31 minutes to bill the code) for psychological testing, and interpretation performed by a PhD level clinical psychologist or psychiatrist. Maximum of 6 units per year.
96102: Similar to 96101, but performed by a technician under the direct supervision of a PhD level clinical psychologist or psychiatrist. Maximum of 6 units per year.
96103: Testing performed using a computer program performed by a technician under the direct supervision of a PhD level clinical psychologist or psychiatrist. Maximum of 1 unit per year.
96118: Neuropsychological testing performed by a PhD level clinical psychologist or psychiatrist. Maximum of 6 units per year.

Only one behavioral health encounter claim may be submitted per date of service unless a service authorization has been approved. Multiple claims for behavioral health encounter visits on a single date of service must contain different diagnosis/procedure combinations to signify the patient is receiving treatment for a different diagnosis that was acquired subsequent to the first visit.

Other Ambulatory Services

Other ambulatory services provided by an FQHC/FQHC-LAL/RHC are to be listed on the claim using only the applicable standard procedure code.

Special treatment of some services is as follows:

Immunization

When immunization is the only procedure on the claim, the FCHC/FQHC-LAL/RHC will be reimbursed for only the administration of the vaccine, at the fee for service rate. The visit will not be paid at the encounter rate. The actual vaccine for adults age 19 and over will be paid regardless of whether the administration is part of the encounter or reimbursed separately.

SUD MAT Services

If an MAT service is performed on the same day as a medical encounter, refer to Medical Services Encounters above for billing instructions.

Maternity Related (Pre-natal, Obstetric Delivery and Post-Partum) Services

Payment for maternity related services (prenatal, obstetric delivery and post-partum services) for female patients enrolled as a primary care patient of an FQHC/FQHC-LAL/RHC shall be made as follows:

- Prenatal visit, defined as a face-to-face office visit, will be paid at the FQHC/FQHC-LAL/RHC encounter rate, using the following codes:
  - 99214 shall be used for the first pre-natal visit with the "TH" modifier; and
  - 99213 shall be used for all other pre-natal visits with the "TH" modifier.
- Obstetric Delivery provided in an inpatient hospital setting shall be billed and reimbursed as FFS using the following codes:
  - 59409: Vaginal delivery with or without episiotomy and/or forceps;
  - 59514: Cesarean section (C-Section) delivery only;
  - 59612: V-BAC delivery with or without episiotomy; and
  - 59620: C-Section after attempted V-BAC delivery.
- An inpatient visit post-delivery, and prior to discharge shall be reimbursed as FFS using the following CPT code:
  - 99231: Inpatient subsequent care, 15 minutes
- Post-partum visit, which is defined as an in-office, face–to-face visit 60 days post-partum, is reimbursed at the FQHC/FQHC-LAL/RHC encounter rate using the following CPT code:
  - 59430: Office or outpatient visit following vaginal or C-Section delivery.

13. Appendix 1 – Procedure Codes

CPT	Transaction Description	Payment
11000	Debride Infected Skin	Fee for Service
11200	Remove Skin Tags	Fee for Service
11400	Remove Skin Lesion	Fee for Service
15839	Excision, Excessive Skin	Fee for Service
31622	Lung Exam	Fee for Service
36406	Vein Puncture Younger <3yrs	Encounter
43239	Gastroscopy	Fee for Service
44180	Laparoscopy, Surgical	Fee for Service
45330	Instr Colon Exam	Fee for Service
45560	Rectal Surgery	Fee for Service
47562	Laparoscopy Cholecystecto	Fee for Service
49320	Diag Laparo Separate Proc	Fee for Service
49322	Laparoscopy Aspiration	Fee for Service
49561	Surgery Repair Inc. Hernia	Fee for Service
52000	Bladder Surgery	Fee for Service
51701	Insert Bladder Catheter	Encounter
51702	Insert Temp. Bladder Catheter	Encounter
51703	Insert Bladder Catheter - Complicated	Encounter
54150	Circumcision Clamp	Fee for Service
54332	Revise Penis/ Urethra	Fee for Service
55250	Vasectomy Unilat B	Fee for Service
56405	Incision and Drainage of Vulva or Perineal Abscess	Fee for Service
56420	Incision Drainage	Fee for Service
56440	Marsupialization B	Fee for Service
56740	Vaginal Surgery	Fee for Service
56810	Gynecology Surgery	Fee for Service
57100	Biopsy Vaginal Mucosa	Fee for Service
57135	Remove Vaginal	Fee for Service
57230	Repair Urethrocele	Fee for Service
57240	Vaginal Suture	Fee for Service
57250	Vaginal Repair	Fee for Service
57260	Vaginal Surgery	Fee for Service
57265	Vaginal, with Enterocele, Repair	Fee for Service
57267	Insertion of Mesh Prosthe	Fee for Service
57268	Repair of Bowel Bulge	Fee for Service
57288	Sling Operation for Stres	Fee for Service

CPT	Transaction Description	Payment
57410	Pelvic Examination	Fee for Service
57454	Colposcopy of Cervix including upper/adjacent vagina w/ Bx/currett of cervix w/ scope	Fee for Service
57455	Colposcopy of Cervix including upper/adjacent vagina W Biops	Fee for Service
57460	Colposcopy of the Cervix Including Upper/Adjacent Vagina w/ loop electrode biopsy of cervix	Fee for Service
57461	Colposcopy of Cervix including upper/adjacent vagina with loop electrode conization of the cervix	Fee for Service
57520	Cervix Biopsy	Fee for Service
57522	Cervix Procedure	Fee for Service
57558	Surgery - D&C of Cervical Stump	Fee for Service
58120	Dil and Curr Diag DIL AND CURR DIAG	Fee for Service
58150	Oper on Uterus	Fee for Service
58152	Hysterectomy	Fee for Service
58180	Hysterectomy Y	Fee for Service
58260	Vaginal Hysterectomy	Fee for Service
58262	Vag Hyst including t/o	Fee for Service
58267	Hysterectomy	Fee for Service
58270	Hysterectomy	Fee for Service
58300	Insertion of IUD	Encounter
58301	Removal of IUD	Encounter
58340	Uterus Tubal Dy Ex	Fee for Service
58353	Endometr Ablate Thermal	Fee for Service
58400	Uterus Surgery	Fee for Service
58541	Surgery - Lsh Uterus 250 g or less	Fee for Service
58542	Surgery - Lsh w/t/o Ut 250 g or less	Fee for Service
58550	Laparo Asst Vag Hysterect	Fee for Service
58552	Laparoscopy W Hyst W Tube	Fee for Service
58555	Hysteroscopy Dx Sep Proc	Fee for Service
58558	Hysteroscopy Biopsy	Fee for Service
58561	Hysteroscopy Remove Myoma	Fee for Service
58563	Hysteroscopy Ablation	Fee for Service
58570	Surgery - Tih Uterus 250 g or less	Fee for Service
58571	Surgery - Tih w/t/o 250g or less	Fee for Service
58572	Surgery - Tih Uterus over 250g	Fee for Service
58573	Surgery - Tih w/t/o Uterus over 250g	Fee for Service
58600	Tubal Ligation	Fee for Service
58605	Tubal Ligation	Fee for Service
58611	Tubal Ligation @ C Section	Fee for Service
58660	Laparoscopy Lysic	Fee for Service
58661	Laparoscopy Remove Adnexa	Fee for Service

CPT	Transaction Description	Payment
58662	Laparoscopy Excise Lesion	Fee for Service
58670	Laparoscopy Tubal Cautery	Fee for Service
58671	Laparoscopy Tubal Block	Fee for Service
58672	Laparoscopy Fimbioplasty	Fee for Service
58673	Laparoscopy Salpingostomy	Fee for Service
58700	Removal of Fallopian Tube	Fee for Service
58720	Removal of Ovary/Tube	Fee for Service
58800	Drainage Ovarian C	Fee for Service
58925	Removal of Ovarian Cyst	Fee for Service
58940	Removal of Ovary	Fee for Service
59000	Amniocentesis	Fee for Service
59025	Fetal Non-Stress Test	Fee for Service
59151	Treat Ectopic Pregnancy	Encounter
59160	Dilat and Curettag	Fee for Service
59200	Insert Cervical Dilator	Fee for Service
59300	Episiotomy/Other T	Fee for Service
59409	Vaginal Delivery Only	Fee for Service
59412	Surgery	Fee for Service
59414	Surgery - Deliver Placenta	Fee for Service
59430	Office or Outpatient Visit following Vaginal or C-Sect Delivery	Encounter
59514	Cesarean Section (C-Section) Delivery Only	Fee for Service
59612	V-BAC delivery only	Fee for Service
59620	C-Section after attempted V-BAC delivery	Fee for Service
59812	Surgery - Treatment of Miscarriage	Fee for Service
59820	Missed Abortion	Fee for Service
59821	Surgery - Treatment of Miscarriage	Fee for Service
59840	Abortion	Fee for Service
62270	Spinal Puncture LU	Encounter
70110	X-Ray Exam of Jaw 4/>Views	Fee for Service
70150	X-Ray Exam of Facial Bones	Fee for Service
70160	X-Ray Exam of Nasal Bones	Fee for Service
70220	X-Ray Exam of Sinuses	Fee for Service
70240	X-Ray Exam of Pituitary Saddle	Fee for Service
70260	X-Ray Exam of Skull	Fee for Service
70328	X-Ray Exam of Jaw Joint	Fee for Service
72040	X-Ray Exam of Neck Spine 3/<ws	Fee for Service
72190	X-Ray Exam of Pelvis	Fee for Service
73030	X-Ray Exam of Shoulder	Fee for Service
73080	X-Ray Exam of Elbow	Fee for Service
73130	X-Ray Exam of hand	Fee for Service

CPT	Transaction Description	Payment
73562	X-Ray Exam of Knee 3	Fee for Service
73590	X-Ray Exam of Lower Leg	Fee for Service
73650	X-Ray Exam of Heel	Fee for Service
76805	Ob us>1=14 Wks Single Fetus	Fee for Service
81002	Urinalysis, By Dip Stick or Tablet Reagent	Fee for Service
81025	Urine Pregnancy Test	Encounter
82270	Occult Blood Feces	Fee for Service
82565	Creatinine, Blood	Fee for Service
83036	Glycosylated Hemoglobin	Fee for Service
84153	Assay of PSA total	Fee for Service
84540	Assay of Urine/Urea-n	Fee for Service
85018	Hemoglobin, Blood count	Fee for Service
85610	Prothrombin Time	Fee for Service
86318	Immunoassay Infectious Agent	Fee for Service
87081	Culture Screen Only	Fee for Service
87220	Tissue Exam for Fungi	Fee for Service
88150	Cytoplast C/V Manual	Fee for Service
90384	RHO(D) Immune Globulin (RHIG), Human full dose, for intramuscular use	Fee for Service
90460	Immunization Administration through 18 Years (Initial)	Fee for Service
90461	Immunization Administration through 18 Years (Add Units)	Fee for Service
90471	Immunization Administration, 1 vaccine	Fee for Service
90472	Immunization Administration, each additional vaccine	Fee for Service
90473	Immun Admin by Intranasal or Oral Route 1 Vaccine	Fee for Service
90474	Immun Admin by Intranasal or Oral Route each Add Vaccine	Fee for Service
90632	Hepatitis A Vac Adult Dos for Intramuscular Use Initial	Fee for Service
90632 SL	Hepatitis A Vac Adult Dos for Intramuscular Use Addit	Fee for Service
90636	Hepatitis A & B Vac Adult Dosage for Intramuscular Use	Fee for Service
90649	Human Papilloma Virus (HPV) Vac, Types 6,11,16,18 1st	Fee for Service
90649 SL	Human Papilloma Virus (HPV) Vac, Types 6,11,16,18 Additional	Fee for Service
90650	Human Papilloma Virus (HPV) Vac, Types 16,18, Bivalent 3 Dos	Fee for Service
90653	Vaccine for Influenza Virus Injection into Muscle	Fee for Service
90654	Influenza Virus Vac split virus, Preservative Free for Intraderm	Fee for Service
90656	Influenza Virus Vaccine, over 3 yrs	Fee for Service
90656 SL	Influenza Virus Vaccine, over 3 yrs	Fee for Service
90658	Influenza Virus Vaccine Split Virus 3 yrs and above intramuscul	Fee for Service
90658 SL	Influenza Virus Vaccine Split Virus 3 yrs and above intramuscul	Fee for Service
90660	Influenza Virus VaccineLive for Intranasal use	Fee for Service
90660 SL	Influenza Virus VaccineLive for Intranasal use	Fee for Service
90661	Influenza Virus Vaccine, Antibiotic Free, for Intramuscular use	Fee for Service
90662	Influenza Virus Vaccine, Split Virus, Pres. Free, Enh. Immunoge	Fee for Service

CPT	Transaction Description	Payment
90664	Influenza Virus, Pandemic Form. Live for Intranasal Use	Fee for Service
90666	Intamuscular use Influenza Virus Vac Pandemic Form Pres Fre	Fee for Service
90667	Influenza Virus Vac, Intramuscular, Pandemic, Pres. Free Split	Fee for Service
90668	Influenza Virus Vac, Intramuscular, Pandemic, Pres. Free Split	Fee for Service
90670	Pneumococcal Conjugate Vac, 13 Valent, Intramuscular Use Ini	Fee for Service
90670 SL	Pneumococcal Conjugate Vac, 13 Valent, Intramuscular Use Ad	Fee for Service
90672	Vaccine for Influenza for Nasal Administration First	Fee for Service
90672 SL	Vaccine for Influenza for Nasal Administration Subsequent	Fee for Service
90685	Vaccine for influenza for administration into muscle, 0.25 ml dosage	Fee for Service
90685 SL	Vaccine for influenza for administration into muscle, 0.25 ml dosage	Fee for Service
90686	Vaccine for influenza for administration into muscle, 0.5 ml dosage	Fee for Service
90686 SL	Vaccine for influenza for administration into muscle, 0.5 ml dosage	Fee for Service
90688	Vaccine for influenza for administration into muscle, 0.5 ml dosage	Fee for Service
90688 SL	Vaccine for influenza for administration into muscle, 0.5 ml dosage	Fee for Service
90707	Immunization, Act, Measles, Mumps and Rubella Vac 1st	Fee for Service
90707 SL	Immunization, Act, Measles, Mumps and Rubella Vac Addit	Fee for Service
90714	Dipth Tet Immunization Typhoid Vaccine	Fee for Service
90714 SL	Dipth Tet Immunization Typhoid Vaccine	Fee for Service
90715	Tet, Diphtheria Toxoids and Acellular Pertussis Vac (TDAP) 1st	Fee for Service
90715 SL	Tet, Diphtheria Toxoids and Acellular Pertussis Vac (TDAP) Add	Fee for Service
90716	Varicella (Chicken Pox) Vaccine 1st	Fee for Service
90716 SL	Varicella (Chicken Pox) Vaccine Additional	Fee for Service
90733	Immunization Act Meningococcal Polysac Vac Any Group (S) 1St	Fee for Service
90733 SL	Immunization Act Meningococcal Polysac Vac Any Group (S)Add	Fee for Service
90734	Meninggococcal Conjugate Vac, Serogroups, Acy and W-135 1st	Fee for Service
90734 SL	Meninggococcal Conjugate Vac, Serogroups, Acy and W-135 Ad	Fee for Service
90736	Zoster (Shingles) Vac, Live for Subcutaneous Injection	Fee for Service
90739	Vac for Hepatitis B Adult Dosage (2 Dose Sch)Inj in Muscl	Fee for Service
90740	Hepatitis B Vac, Dialysis or Immunosupressed Pat .3 Dose Sch	Fee for Service
90746	Hepatitis B Vac Adult Dose Intramuscular First	Fee for Service
90746 SL	Hepatitis B Vac Adult Dose Intramuscular Add.	Fee for Service
90747	Hepatitis B Vac Dialysis or Immunosuppressed Pt.4 Dose Sch	Fee for Service
90749	Unlisted Vaccine	Fee for Service
90785	Interactive Complexity	Encounter

CPT	Transaction Description	Payment
90791	Psych Diagnosis Evaluation	Encounter
90792	Psych Diagnosis with Eval and Mgt Service	Encounter
90832	Psychotherapy, 30 min, w/ Patient and /or Family Members	Encounter
90833	Psychotherapy, 30 min, w/ Patient and /or Fam Mem/Mgt Svc	Encounter
90834	Psychotherapy, 45 min, w/ Patient and /or Family Members	Encounter
90836	Psychotherapy, 45 min, w/ Patient and /or Fam Mem/Mgt Svc	Encounter
90837	Psychotherapy, 60 min, w/ Patient and /or Family Members	Encounter
90838	Psychotherapy, 60 min, w/ Patient and /or Fam Mem/Mgt Svc	Encounter
90846	Family Psych Visit w/o Patient	Encounter
90847	Family Psych with Patient	Encounter
90853	Group Psychotherapy	Encounter
92285	Eye Photography	Fee for Service
92587	Evoked Auditory Test Limit	Fee for Service
92977	Dissolve Clot Heart Vessel	Fee for Service
93010	Electrocardiogram Report	Fee for Service
93015	Cardiovascular Stress Test	Fee for Service
93016	Physician Service, Cardiovascular Stress Test	Fee for Service
93018	Heart Stress Test I&R Onl	Fee for Service
93225	Diagnostic Laboratory	Fee for Service
93226	Diagnostic Laboratory	Fee for Service
93227	Heart Tracing	Fee for Service
93307	Echo Exam of Heart	Fee for Service
93320	Doppler Echo Exam Heart	Fee for Service
93325	Diagnostic Laboratory	Fee for Service
94010	Breathing Capacity Test	Fee for Service
94070	Eval of Wheezing	Fee for Service
94200	Lung Funct Exam	Fee for Service
94375	Breathing Test-Respiratory Flow	Fee for Service
94681	Diagnostic Laboratory	Fee for Service
94726	Plethysmography for Determination of Lung Volumes	
94727	Pulm Function Test by Gas	Fee for Service
94728	Pulm Function Test – Oscillometry	Fee for Service
94729	Co / Membrane Diffuse Capacity	Fee for Service
94760	Measure Blood Oxygen Level	Fee for Service
94761	Diagnostic Laboratory	Fee for Service
94762	Bld/Oxygen Test	Fee for Service
95070	Bronchial Allergy Test	Fee for Service
96101	Psych Testing w Psych Assessment	Fee for Service
96102	Psych Testing w Psych Assessment, performed by a technician	Fee for Service
96103	Psych Test w Psych Assessment using a comp prgrm by a tech	Fee for Service

CPT	Transaction Description	Payment
96110	Developmental Screen	Fee for Service
96111	Developmental Testing	Fee for Service
96118	Neuropsychological Testing	Fee for Service
96372	Injection, therapeutic, prophylactic or diagnostic, sub or intra	Fee for Service
99080	Insurance Form	Fee for Service
99201	Level 1 O/V - New Patient	Encounter
99202	Level 2 O/V - New Patient	Encounter
99203	Level 3 O/V - New Patient	Encounter
99204	Level 4 O/V - New Patient	Encounter
99205	Level 5 O/V - New Patient	Encounter
99211	Level 1 O/V - Established	Encounter
99212	Level 2 O/V - Established	Encounter
99213	Level 3 O/V - Established	Encounter
99214	Level 4 O/V - Established	Encounter
99215	Level 5 O/V - Established	Encounter
99217	Observation Care Dis Mgmt	Fee for Service
99218	Medical Care, Initial Observ.	Fee for Service
99219	Initial Observation E&M	Fee for Service
99220	Medical Care	Fee for Service
99221	Level 1 Inpt Visit	Fee for Service
99222	Level 2 Inpt Visit	Fee for Service
99223	Level 3 Inpt Visit	Fee for Service
99231	Level 1 Inpt Visit, Subsequent	Fee for Service
99232	Level 2 Inpt Visit, Subsequent	Fee for Service
99233	Level 3 Inpt Visit	Fee for Service
99234	Observation for Eval/Mgmt	Fee for Service
99235	Observation for Eval/Mgmt	Fee for Service
99236	Observation	Fee for Service
99238	Hospital Discharge, 30 minutes or less	Fee for Service
99239	Hospital Discharge Mgmt,30+ Minutes	Fee for Service
99241	Level 1 Consultation	Encounter
99242	Level 2 Consultation	Encounter
99243	Level 3 Consultation	Encounter
99244	Level 4 Consultation	Encounter
99245	Level 5 Consultation	Encounter
99251	Level 1 Inpatient Consult	Fee for Service
99252	Level 2 Inpatient Consult	Fee for Service
99253	Level 3 Inpatient Consult	Fee for Service
99254	Level 4 Inpatient Consult	Fee for Service
99255	Level 5 Inpatient Consult	Fee for Service

CPT	Transaction Description	Payment
99281	Level 1 E.R. Visit	Fee for Service
99282	Level 2 E.R. Visit	Fee for Service
99283	Level 3 E.R. Visit	Fee for Service
99284	Level 4 E.R. Visit	Fee for Service
99285	Level 5 E.R. Visit	Fee for Service
99291	Critical Care 1ST Hour	Fee for Service
99292	Critical Care Add'l 30'	Fee for Service
99304	Init. Nursing Facility Visit 25 min.	Encounter
99305	Init. Nursing Facility Visit 35 min.	Encounter
99306	Init. Nursing Facility Visit 45 min.	Encounter
99307	Subsequent Nursing Facility Care 10 min.	Encounter
99308	Subsequent Nursing Facility Care 15 min.	Encounter
99309	Subsequent Nursing Facility Care 25 min.	Encounter
99310	Subsequent Nursing Facility Care 35 min.	Encounter
99313	Level 3 Sub NF Care (Nursing Home)	Encounter
99356	In-Hospital Doctor Visit	Fee for Service
99381	WCC Under age 1 New Patient	Encounter
99382	WCC Age 1-4 New Patient	Encounter
99383	WCC Age 5-11 New Patient	Encounter
99384	WCC Age 12-17 New Patient	Encounter
99385	PE Age 18-39 New Patient	Encounter
99386	PE Age 40-64 New Patient	Encounter
99387	PE Age 65+ New Patient	Encounter
99391	WCC Under age 1 Established	Encounter
99392	WCC Age 1-4 Established	Encounter
99393	WCC Age 5-11 Established	Encounter
99394	WCC Age 12-17 Established	Encounter
99395	PE Age 18-39 Established	Encounter
99396	PE Age 40-64 Established	Encounter
99397	PE Age 65+ Established	Encounter
99401	Preventative Medicine Counseling 15 min	Encounter
99402	Preventative Medicine Counseling 30 min	Encounter
99403	Preventative Medicine Counseling 45 min	Encounter
99404	Preventative Medicine Counseling 60 min	Encounter
99464	Attendance at Delivery	Fee for Service
99460	Initial Hospital or Birthing Center Care	Fee for Service
99462	Subsequent Hospital Care, Per Day	Fee for Service
99463	Same day Newborn Discharge	Fee for Service
G0008	Admin influenza virus vac	Encounter

CPT	Transaction Description	Payment
G0009	Admin Pneumococcal Vac – No Fee Sched. Service	Encounter
G0010	Admin of Hepatitis B Vac - No Fee Sched. Servic	Encounter
J1050	Medroxyprogeserone acetate	Fee for Service
J7300	Intraut copper contraceptive	Fee for Service
J7301	Levonorgestrel iu 13.5 mg	Fee for Service
J7303	Contraceptive vaginal ring	Fee for Service
J7304	Contraceptive hormone patch	Fee for Service
J7306	Levonorgestrel implant sys	Fee for Service
J7307	Etonogestrel implant sys	Fee for Service
J7297	Levonorgestrel iu 52 mg 3 yr	Fee for Service
J7298	Levonorgestrel iu 52 mg 5 yr	Fee for Service
Q2039	Influenza virus vaccine, not otherwise specified	Fee for Service
S0302	Completed EPSDT	Fee for Service
S9982	Copying medical records for disability determination	Fee for Service
T1015	Clinic Visit/Encounter	Encounter
T1027 TH	Family Training and Counseling For Child Development	Fee for Service
H0001	Alcohol and/or Drug Assessment	Fee for Service
H0004, U1	Behavioral Health Counseling and Therapy (30 min session)	Fee for Service
H0004, U2	Behavioral Health Counseling and Therapy (45 min session)	Fee for Service
H0004, U3	Behavioral Health Counseling and Therapy (60 min session)	Fee for Service
H0007, U1	Crisis Intervenion (OP) - In Provider Office or Community (first 60 min)	Fee for Service
H0007, U2	Crisis Intervenion (OP) - In Provider Office or Community (each additional 30 min)	Fee for Service
H0005	Alcohol and/or Drug Services; group counseling by a clinician per person, per session	Fee for Service
H0047, HS, HQ	Counseling, Family-Multi Family Group	Fee for Service
H0047, HR, HQ	Family/couple with client present, group setting	Fee for Service
H0015	Intensive Outpatient Services	Fee for Service
H2036	Partial Hospitalization Services	Fee for Service
H0014	Medically Monitored Withdrawal Management	Fee for Service
T1012	Non Peer Recovery Support, Individual	Fee for Service
T1012, HQ, FS	Non Peer Recovery Support, Group	Fee for Service
H0038	Peer Recovery Support, Individual	Fee for Service
H0038,HQ	Peer Recovery Support, Group	Fee for Service
H0006	Case Management (Continuous Recovery Monitoring-CRM)	Fee for Service
99408	SBIRT, 15-30 min	Encounter
99409	SBIRT, over 30 min	Encounter

14. Acronyms

APM – Alternative Payment Methodology

BIPA – Benefits and Improvement Protection Act

CPT – Current Procedural Terminology

FFS – Fee For Service

FQHC – Federally Qualified Health Center

FQHC-LAL – Federally Qualified Health Center Look A Like

MMIS – Medicaid Management Information System

OMBP – Office of Medicaid Business and Policy

PPS – Prospective Payment System

RHC – Rural Health Clinic

RHC-NHB – Rural Health Clinic-Non Hospital Based