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In reply, please refer to:

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Governor's Referral No.:

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MEMORANDUM

ACS M03-20

TO: Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

FROM: Aileen Hiramatsu, Med-QUEST Division Administrator *AH*

SUBJECT: PROCEDURE CODES TO BE USED WHEN SUBMITTING CLAIMS AND
CORRECTION OF CLAIMS PAID IN ERROR

To expedite the processing of claims submitted for services performed by FQHCs/RHCs, please review your claims submittal processes to assure they meet the following requirements:

- Claims must be submitted on UB92 or dental claim forms or electronically in UB92 or dental format.
- The FQHC/RHC must submit claims for all services provided by its professional staff using its FQHC/RHC provider number. Claims for professional services are not payable on HCFA (CMS)1500 forms or in 1500 format.
- No more than one date of service can be submitted per UB92 claim form per Medicaid recipient.
- Only one claim per day can be submitted for dental services and for each allowable revenue code for a Medicaid covered service.

In its review of the reasons for delays in claims payment for FQHCs/RHCs, the Med-QUEST Division (MQD) discovered that many claims suspend for manual review. We know that by specifying the (Health Care Financing Administration Common Procedural Coding System) HCPCS codes that FQHCs/RHCs should use and the circumstances pertinent to these codes, claims payment will be expedited.

Thus, effective immediately, when Medicaid is the recipient's primary health care insurer, we ask that you limit the codes you use to the following:

Revenue Code	CPT Code	Usage
520	99232	All services performed in the inpatient acute care hospital by FQHC/RHC professional staff including deliveries, circumcisions, inpatient acute care hospital psychotherapy
520	99212	All services performed in all outpatient settings including outpatient hospital emergency rooms/treatment rooms, etc. by FQHC/RCH professional staff
Not needed	D0140	All dental services by FQHC/RHC dentists in all settings, including dental work performed in the outpatient and inpatient hospital settings with/without anesthesia
910	90801-90802	Psychiatric assessments (evaluations) and reassessments (reevaluations) in all inpatient acute care hospital and all outpatient settings
910	90804-90807, 90810-90811, 90847-90853, 90862	Psychotherapy (individual and group) in all outpatient settings, including medication management done on same day as psychotherapy; if done on another day use 520 revenue code with applicable HCPCS code (either 99232 or 99212). Please note that only licensed psychiatrists can use the codes with the specific description, "with medical evaluation and management services."
520	96150-96155	Health and behavioral assessments/interventions ONLY for FQHCs and RCHs with grants to provide integrated behavioral health services
520	92340	Vision services and supplies (such as eye glasses) provided by FQHC/RCH ophthalmologists/optometrists
529	99199	All services NOT covered by Medicaid. If an FQHC chooses to submit a claim for services non-covered by Medicaid, it MUST bill these services as non-covered charges. Failure to include these as non-covered charges will result in over-payments. It is each FQHC's responsibility to inform ACS of ALL overpayments. Recovery of all overpayments is a Medicaid requirement.

We have modified the system to promote the use of these codes.

To expedite the processing of Medicare crossover claims, please use the codes that Medicare has instructed you to use for revenue codes 520 and 910.

CORRECTION OF CLAIMS PREVIOUSLY PAID INCORRECTLY

MQD and ACS will be recycling claims that were processed by HPMMIS with dates of service from November 1, 2002. We will reprocess both paid and denied claims. The reprocessing of these claims will result in the following:

- Non-Medicare claims will pay the PPS rate regardless of the billed charge amount
- Medicare claims will pay the difference between the PPS rate and the Medicare paid amount
- Claims billed on the CMS 1500 form will be denied
- Dental claims billed with D0120 that incorrectly denied for service limits will be paid
- Dental claims not billed with D0120 or D0140 will be denied
- Outpatient claims billed with 99199 or any codes other than 99232, 99212, 90801, 90806, 96150-96155, 92340 will pend to ACS. ACS will non-cover the charges for that service so that the provider will not be overpaid.

Claims affected by this reprocessin will appear on your remittance advice as an adjustment. The remittance advice will show the corrected amount to be paid, the original amount paid and the difference. We anticipate beginning the recycle of the claims during November 2003. We will notify you when it is completed.

For questions or clarification, please contact Ms. Angelina Payne at 692-8083.