Cook Children's Health Plan

FQHC CLAIM BILLING GUIDELINES

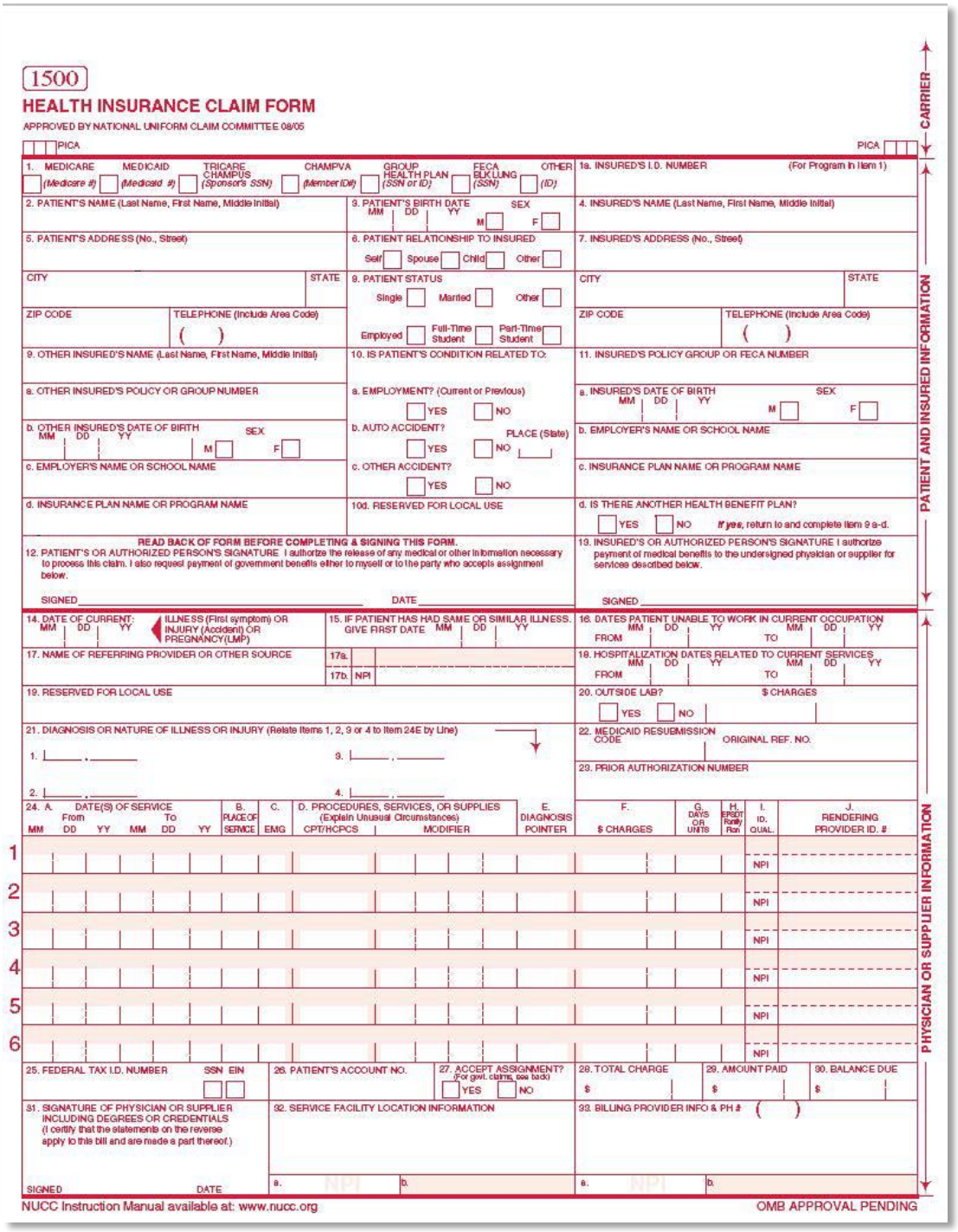
STAR/STAR - Effective 10/01/2017

CHIP - Effective 03/01/2018

1. Procedure code T1015 identifies the claim as Wrap Payment eligible and **must** be billed on a CMS 1500 paper claim form or electronic EDI 837P. T1015 should be reported on the 1st line of each claim
2. T1015 should report the FQHC PPS rate
3. All E&M codes should report normal charges or the contracted rate
4. Any subsequent procedure codes inclusive to the Wrap payment should reflect a charge amount equal to or greater than $0.01
5. Each service category (Family Planning*, Texas Health Steps (Well Child Exam and Acute Care) should be billed on separate claims. When a preventative medical checkup is billed on the same date of service as an acute care visit, providers must append Modifier 25 on the first position to HCPC T1015 and E&M CPT code.
6. Box 24J - Rendering Provider NPI and Taxonomy is required
7. Box 32 – FQHC Service Facility Address is required
8. Box 32A – FQHC Service Facility NPI is required
9. Box 32B – FQHC Service Facility Taxonomy is required
10. Box 33 - FQHC Facility Name and Physical Address is required — P.O. Box address not payable
11. Box 33A - FQHC Facility NPI is required
12. Box 33B - FQHC Facility Taxonomy is required

*not available for CHIP

STANDARD CMS 1500 CLAIMS FORM SAMPLE



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

9. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

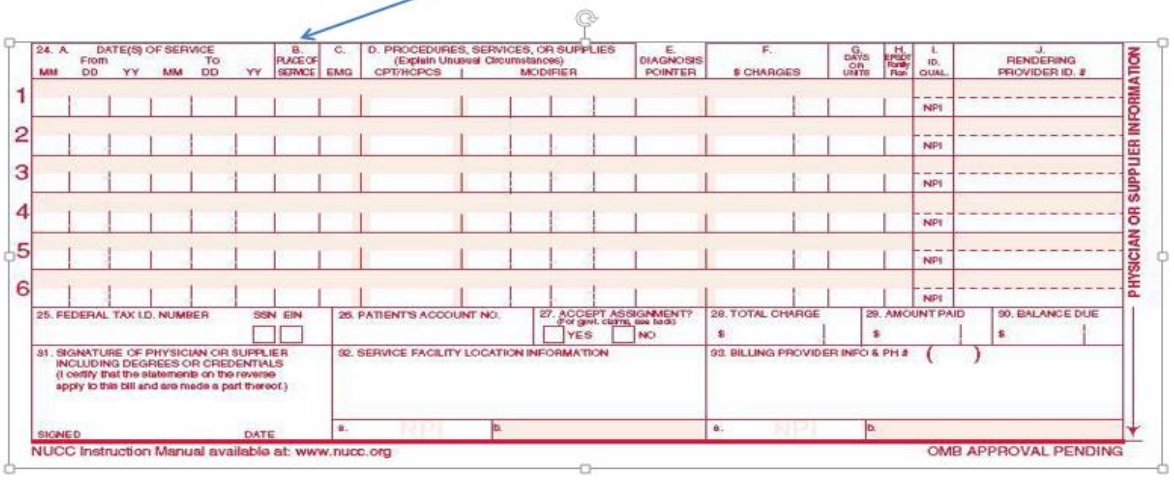
OMB APPROVAL PENDING

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

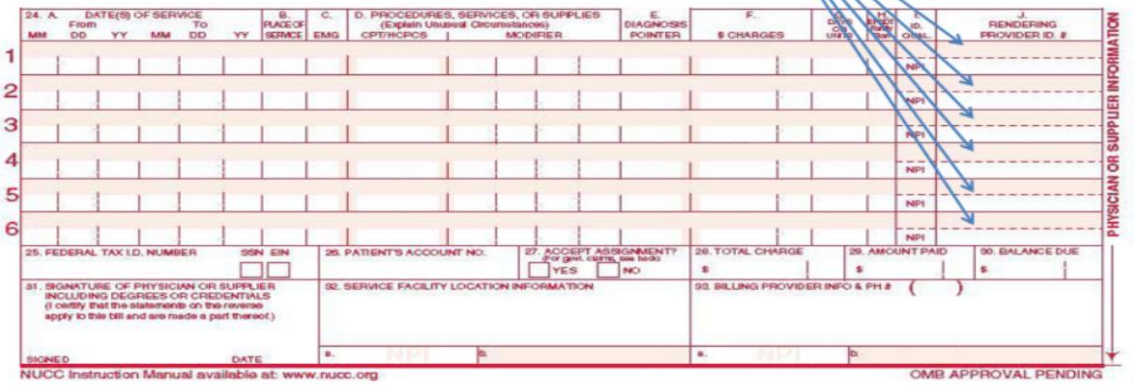
Box 24 B: FQHCs to enter 50 as code for place of service



Rationale: Place of service code "50" identifies entity as FQHC.

10

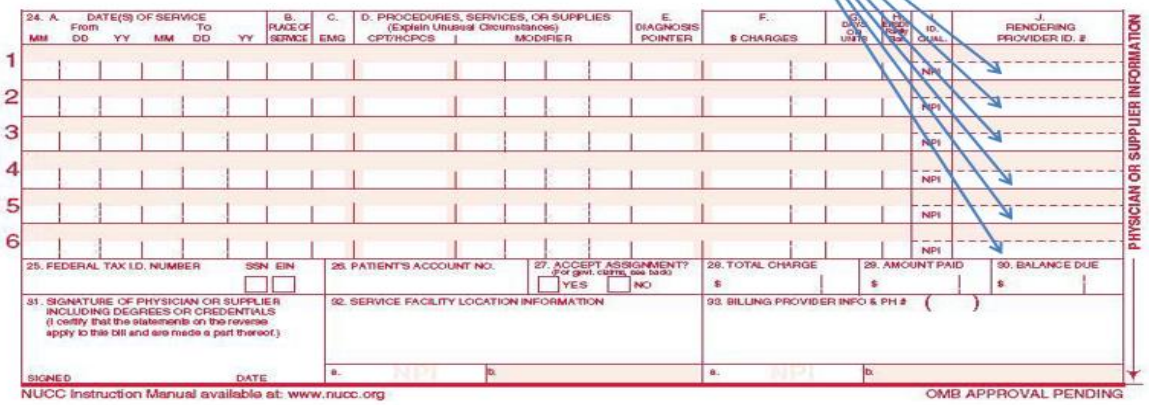
Box 24 I (shown as top part of each billing line in Column J): FQHCs to enter rendering provider taxonomy



Rationale: Adds taxonomy identifier of rendering provider on all claims.

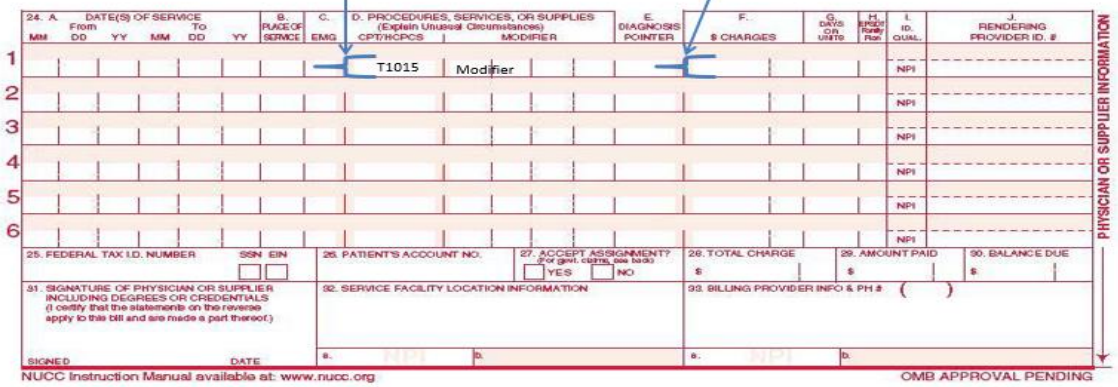
11

Box 24 J: FQHCs to enter rendering provider National Provider Identifier (NPI)



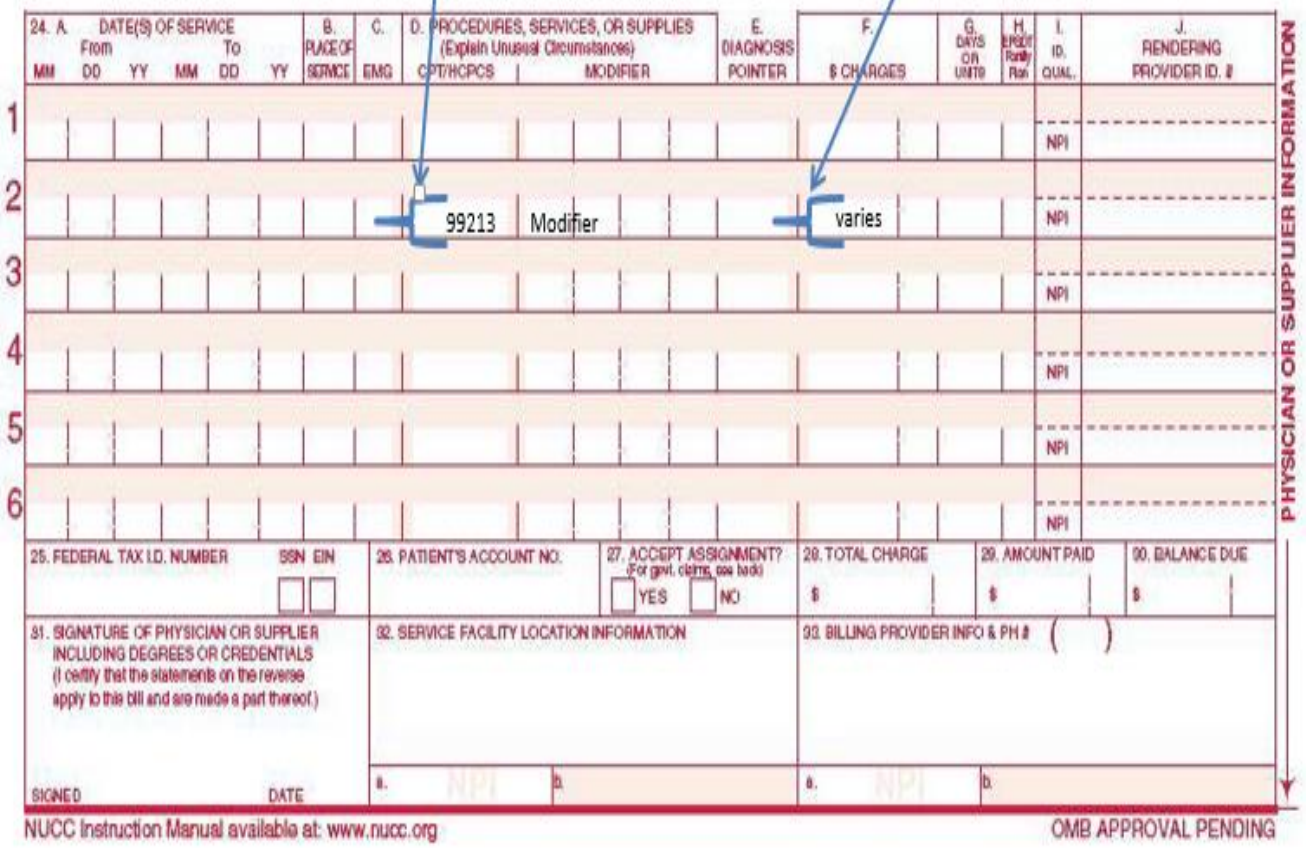
Rationale: Continues to require rendering provider NPI on all claims.

Box 24: FQHCs to enter T1015 code and appropriate modifier in line 1, column D, and PPS rate in line 1, column F. Value varies.



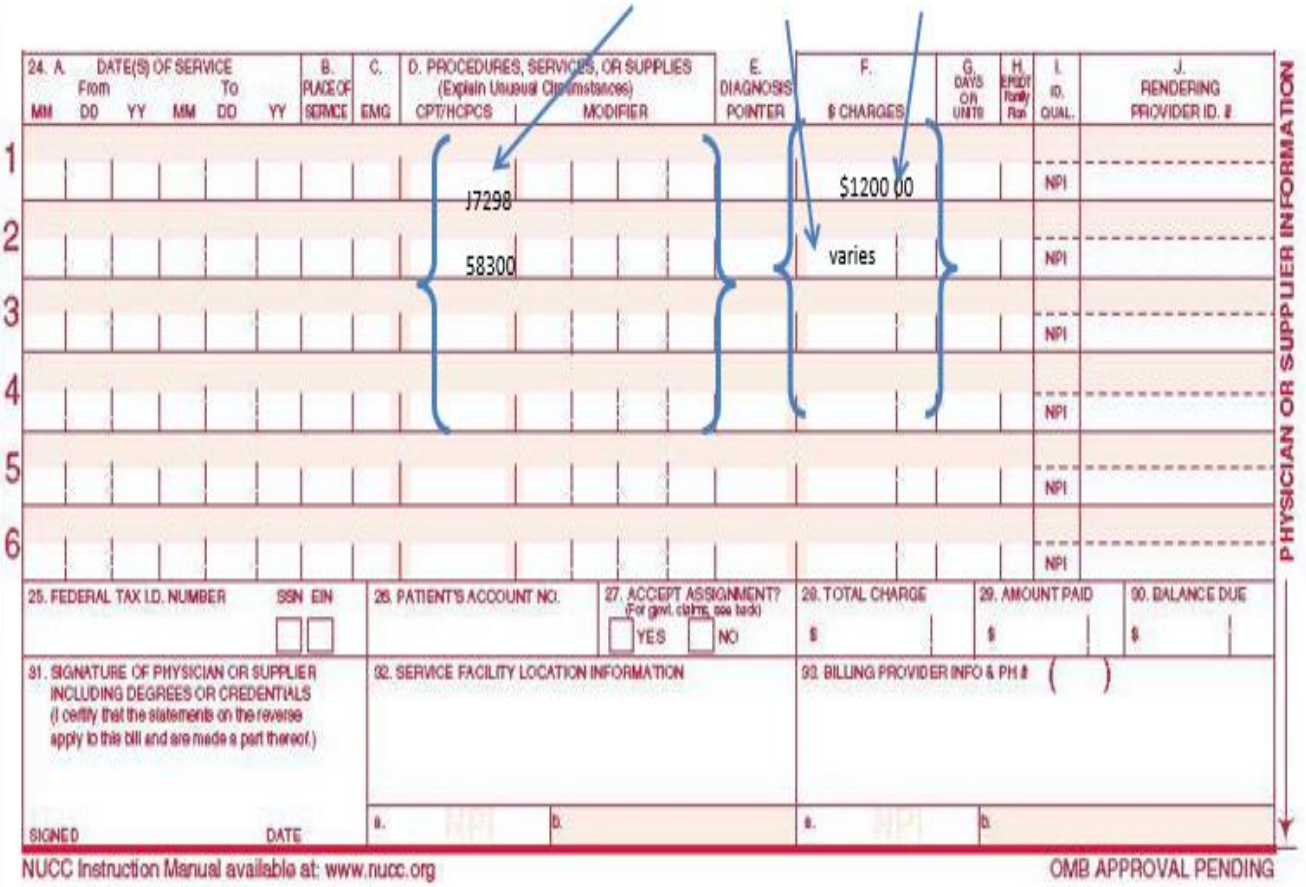
Rationale: Provides encounter identifier and rate. Box 24, Column F Line 1, value is PPS rate.

Box 24: FQHCs to enter CPT code and appropriate modifier that triggers the T1015 in line 2, column D, billed charges are normal charges or contracted rate



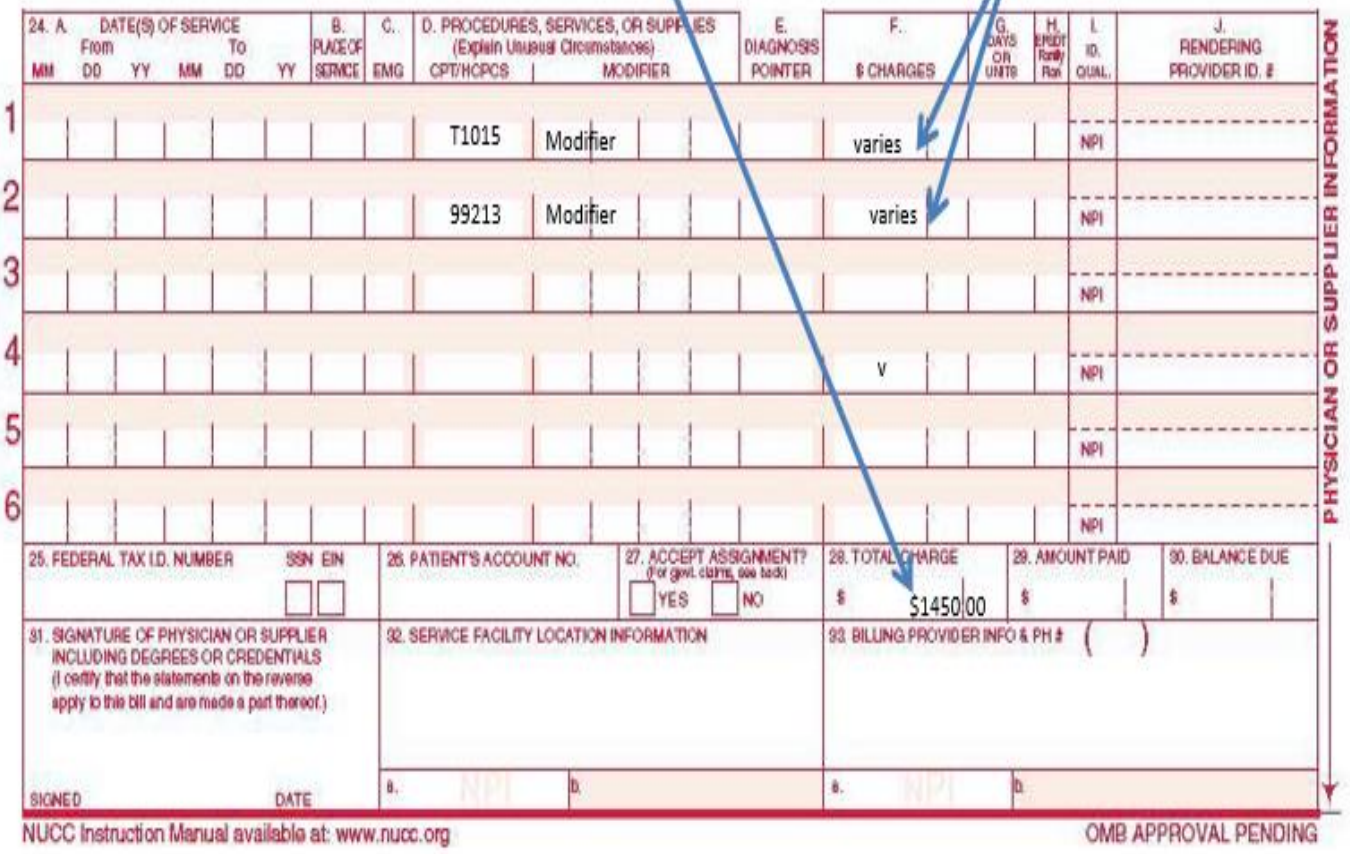
Rationale: Provides CPT code that triggers the T1015 encounter code.

Box 24: FQHCs to enter CPT codes and modifiers for <u>all services</u> delivered during patient visit in lines 1,2, column D. Line item charges from the centers fee schedule for items excluded from the PPS rate are entered in lines 1,2, column F. All line items excluded from PPS rate will have billed charges

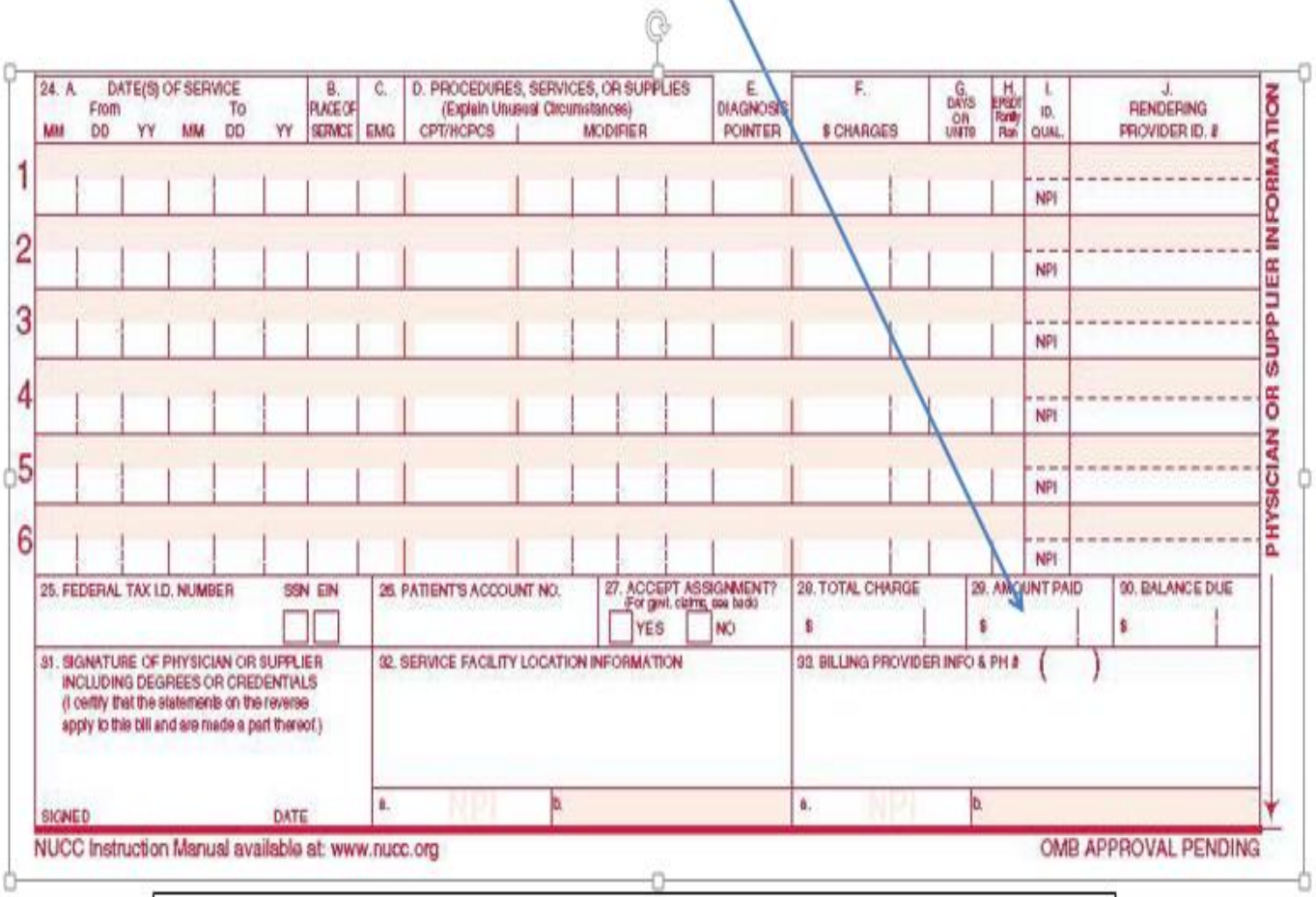


Rationale: Provides all the CPT codes for services provided during patient visit.

Box 28: Total Charges will reflect sum of all charges in column F, lines 1-6. All charges in column F, lines 1-2 that are included in the PPS rate should reflect the PPS rate on T1015 line 1 and contracted rate on E&M code line2, lines 3-6 for services included in the PPS rate should reflect billed charges greater than or equal to $0.01

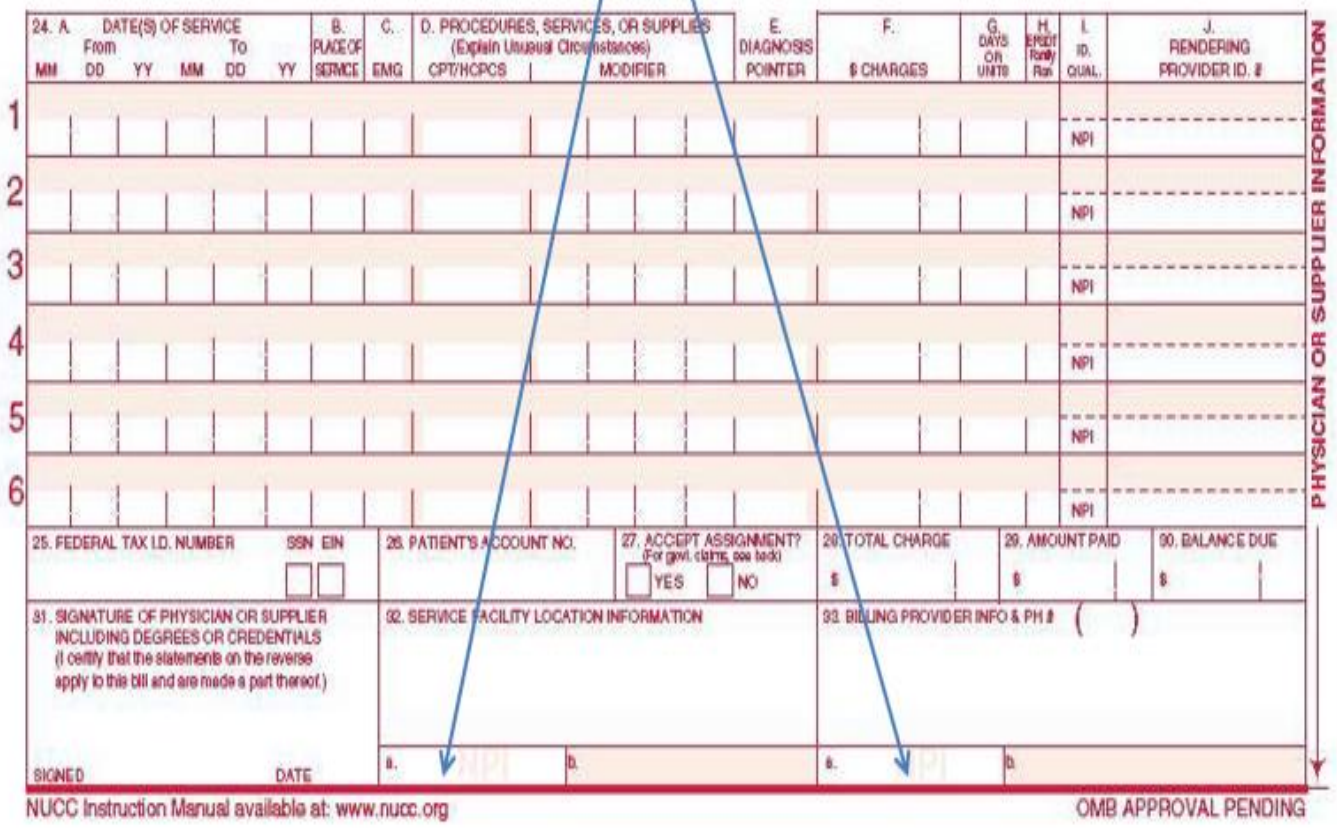


Box 29: FQHCs to enter co-payments, if any.



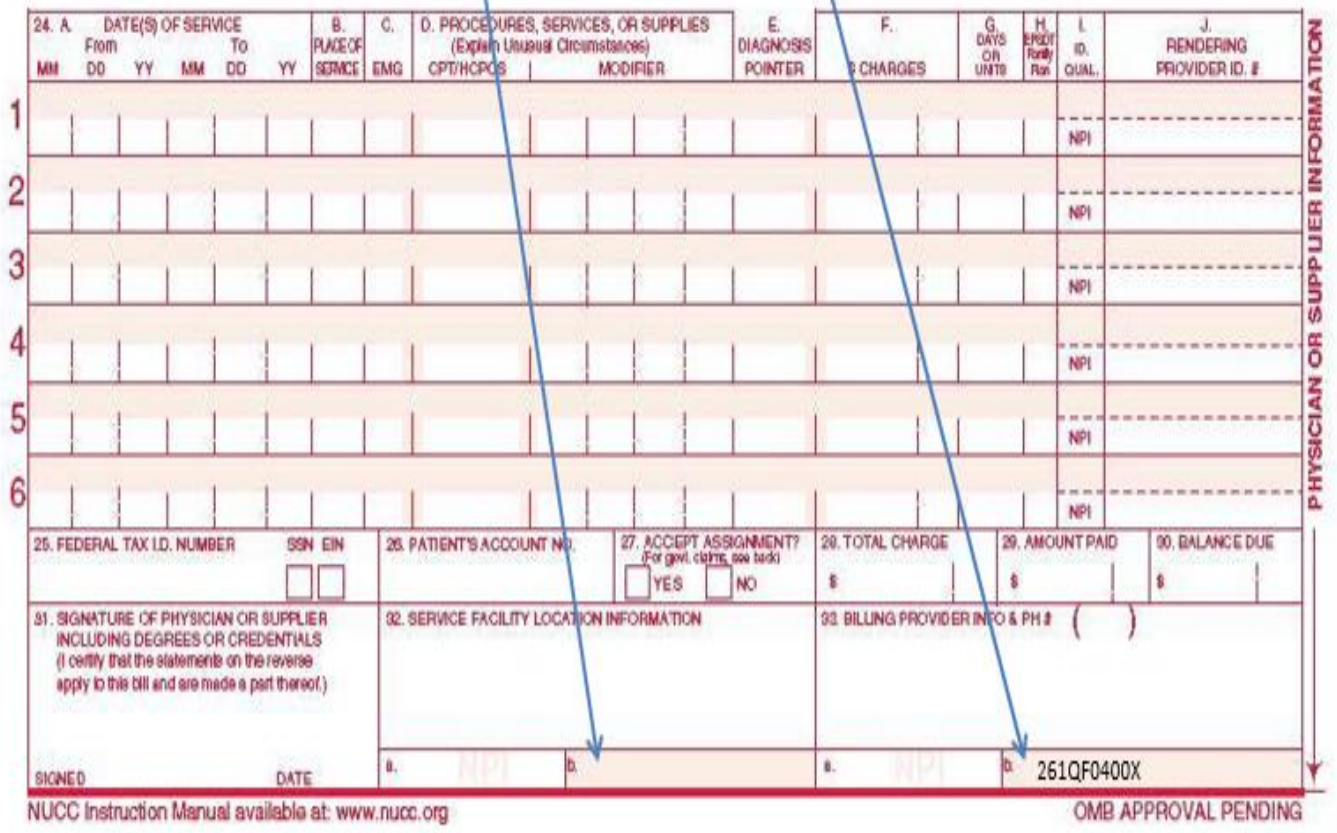
Rationale: No change.

Box 32 a and 33 a: FQHCs to enter service Organization NPI (ONPI) that applies to service location

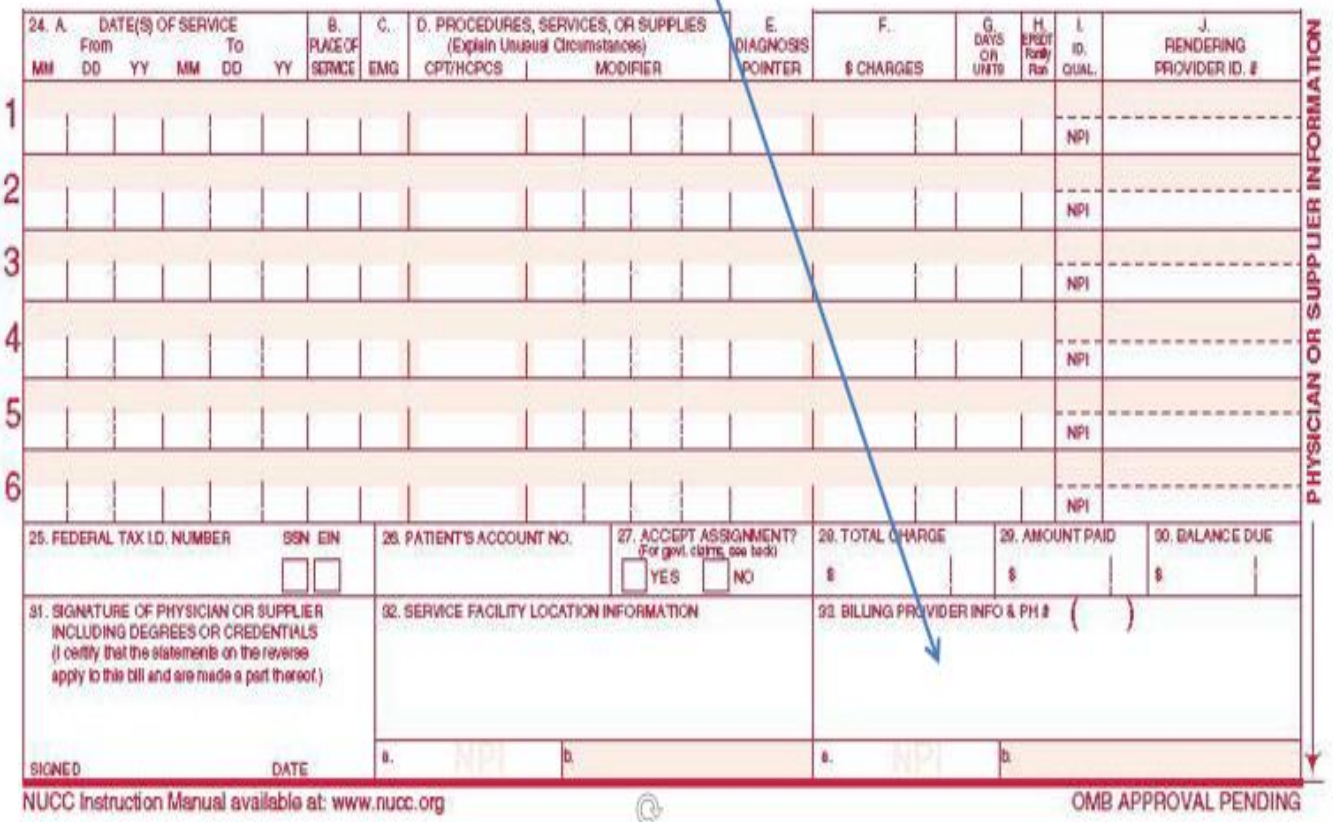


Rationale: Provides service Organization NPI that applies to the service location to confirm service location is enrolled by FQHC in Medicaid program. Please check your numbers.

Box 32 b and 33 b: FQHCs to enter FQHC Facility taxonomy code in box 32 b, and the FQHC Billing taxonomy code in 33 b. 261QF0400X must be used in box 33 b.



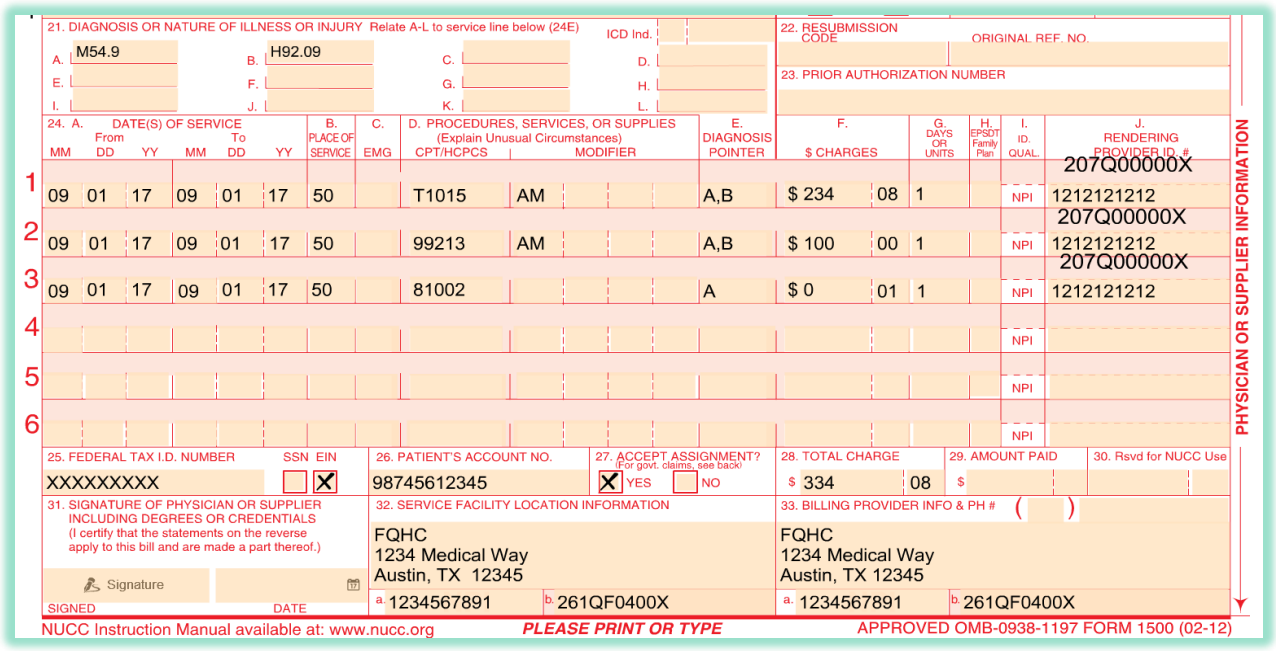
Box 33: FQHCs enter the billing provider information; PO Box **cannot** be used for the billing provider address information.



Rationale: Many FQHCs currently have systems set up to receive payments via a "P.O. Box" rather than a street address. FQHCs will need to work with the MCOs to update their provider file.

CLAIM EXAMPLES

Acute Care



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.
A. M54.9 B. H92.09 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	01	17	09	01	17	50		T1015	AM	A,B	$ 234	08	1	NPI	207Q00000X 1212121212
2	09	01	17	09	01	17	50		99213	AM	A,B	$ 100	00	1	NPI	207Q00000X 1212121212
3	09	01	17	09	01	17	50		81002		A	$ 0	01	1	NPI	207Q00000X 1212121212
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: XXXXXXXXX [ ] [X]
26. PATIENT'S ACCOUNT NO.: 98745612345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE: $ 334 08
29. AMOUNT PAID: $
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FQHC
1234 Medical Way
Austin, TX 12345
a. 1234567891 b. 261QF0400X

33. BILLING PROVIDER INFO & PH # ( )
FQHC
1234 Medical Way
Austin, TX 12345
a. 1234567891 b. 261QF0400X

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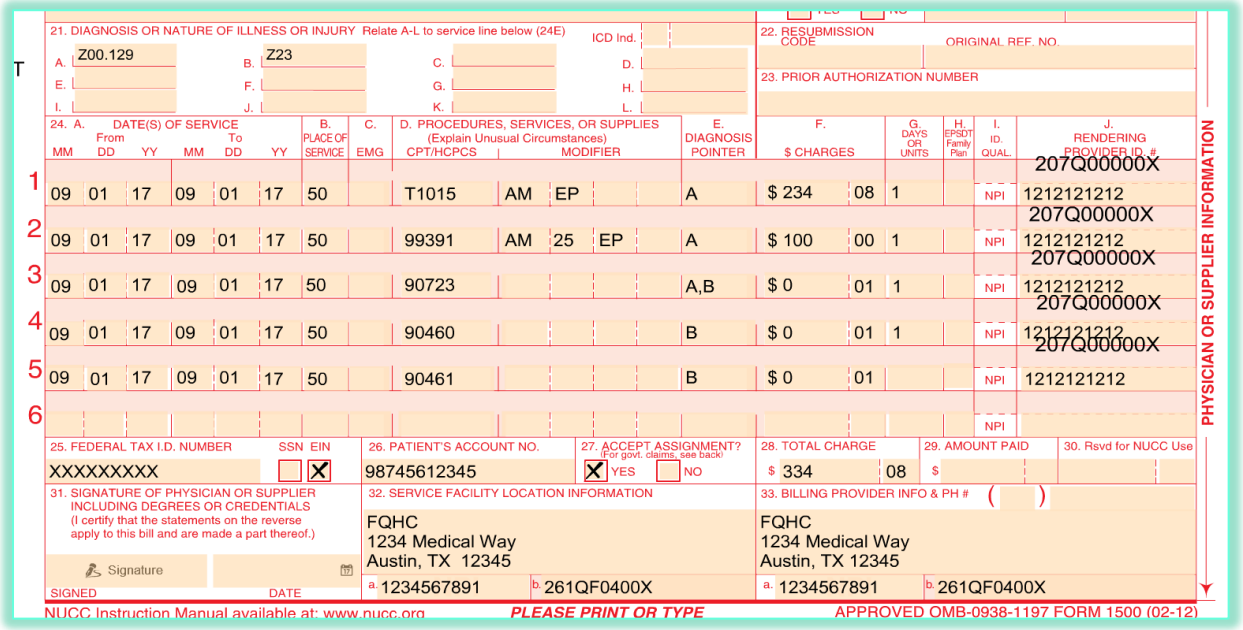
Texas Health Steps / Well Child Exam



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.
A. Z00.129 B. Z23 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	01	17	09	01	17	50		T1015	AM EP	A	$ 234	08	1	NPI	207Q00000X 1212121212
2	09	01	17	09	01	17	50		99391	AM 25 EP	A	$ 100	00	1	NPI	207Q00000X 1212121212
3	09	01	17	09	01	17	50		90723		A,B	$ 0	01	1	NPI	207Q00000X 1212121212
4	09	01	17	09	01	17	50		90460		B	$ 0	01	1	NPI	207Q00000X 1212121212
5	09	01	17	09	01	17	50		90461		B	$ 0	01		NPI	207Q00000X 1212121212
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: XXXXXXXXX [ ] [X]
26. PATIENT'S ACCOUNT NO.: 98745612345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE: $ 334 08
29. AMOUNT PAID: $
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FQHC
1234 Medical Way
Austin, TX 12345
a. 1234567891 b. 261QF0400X

33. BILLING PROVIDER INFO & PH # ( )
FQHC
1234 Medical Way
Austin, TX 12345
a. 1234567891 b. 261QF0400X

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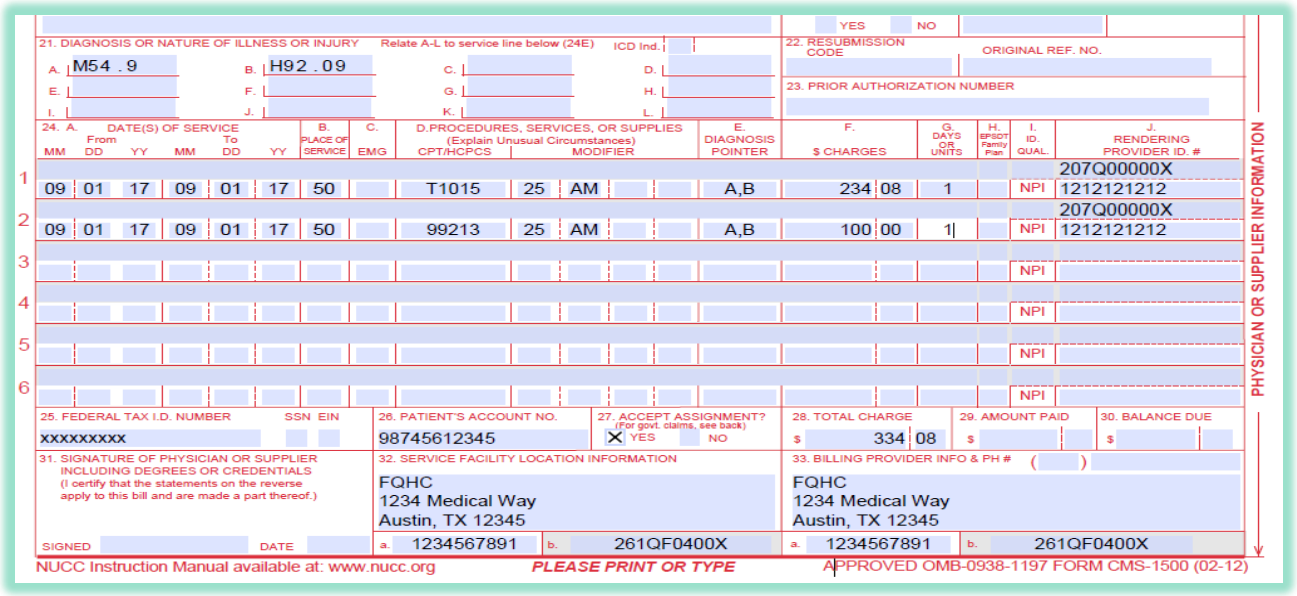
Acute Care on the same date of service as a Texas Health Steps (Well Child exam) visit with modifier 25 on the 1st position



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))				ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. M54.9	B. H92.09	C.	D.		23. PRIOR AUTHORIZATION NUMBER	
E.	F.	G.	H.			
I.	J.	K.	L.			

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	01	17	09	01	17	50		T1015	25 AM	A,B	234 00	1		NPI	207Q00000X 1212121212
2	09	01	17	09	01	17	50		99213	25 AM	A,B	100 00	1		NPI	207Q00000X 1212121212
3															NPI	
4															NPI	
5															NPI	
6															NPI	

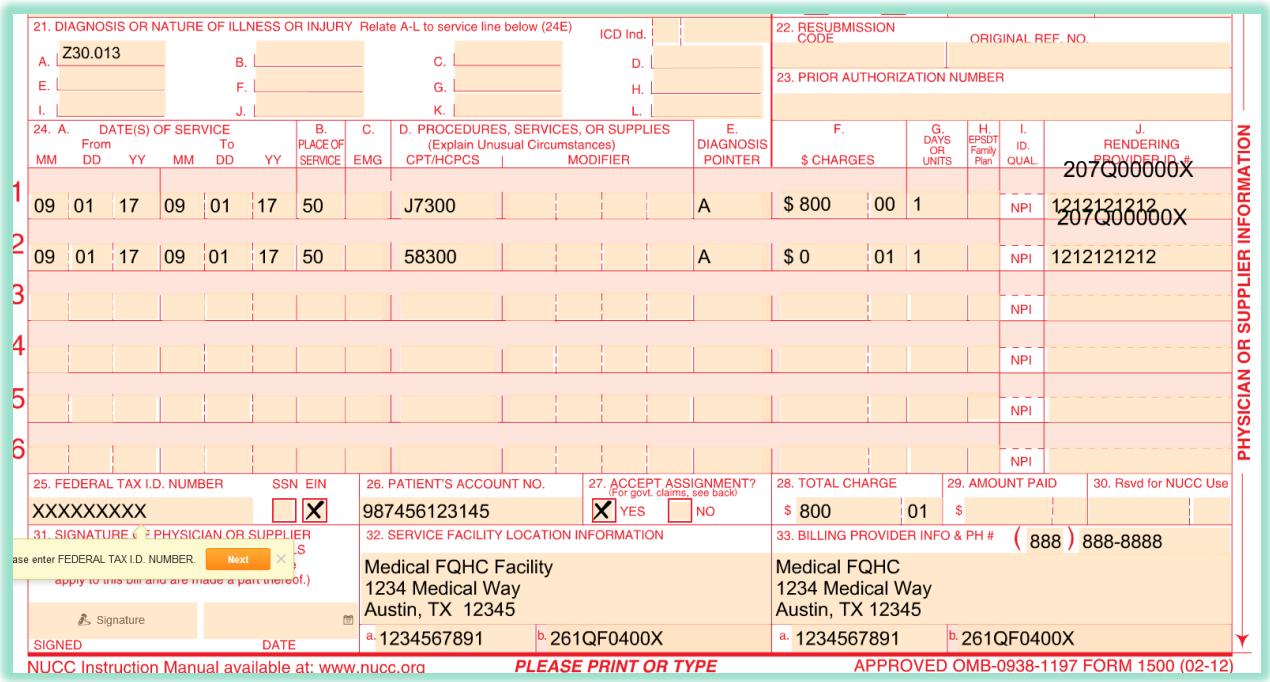
25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
xxxxxxxxx		98745612345	X YES NO	$ 334 08	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SIGNED DATE	FQHC 1234 Medical Way Austin, TX 12345	FQHC 1234 Medical Way Austin, TX 12345
	a. 1234567891 b. 261QF0400X	a. 1234567891 b. 261QF0400X

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Family Planning Claim eligible for FFS rates (*Does not apply to CHIP)



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))				ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. Z30.013	B.	C.	D.		23. PRIOR AUTHORIZATION NUMBER	
E.	F.	G.	H.			
I.	J.	K.	L.			

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	01	17	09	01	17	50		J7300		A	$ 800 00	1		NPI	207Q00000X 1212121212
2	09	01	17	09	01	17	50		58300		A	$ 0 01	1		NPI	207Q00000X 1212121212
3															NPI	
4															NPI	
5															NPI	
6															NPI	

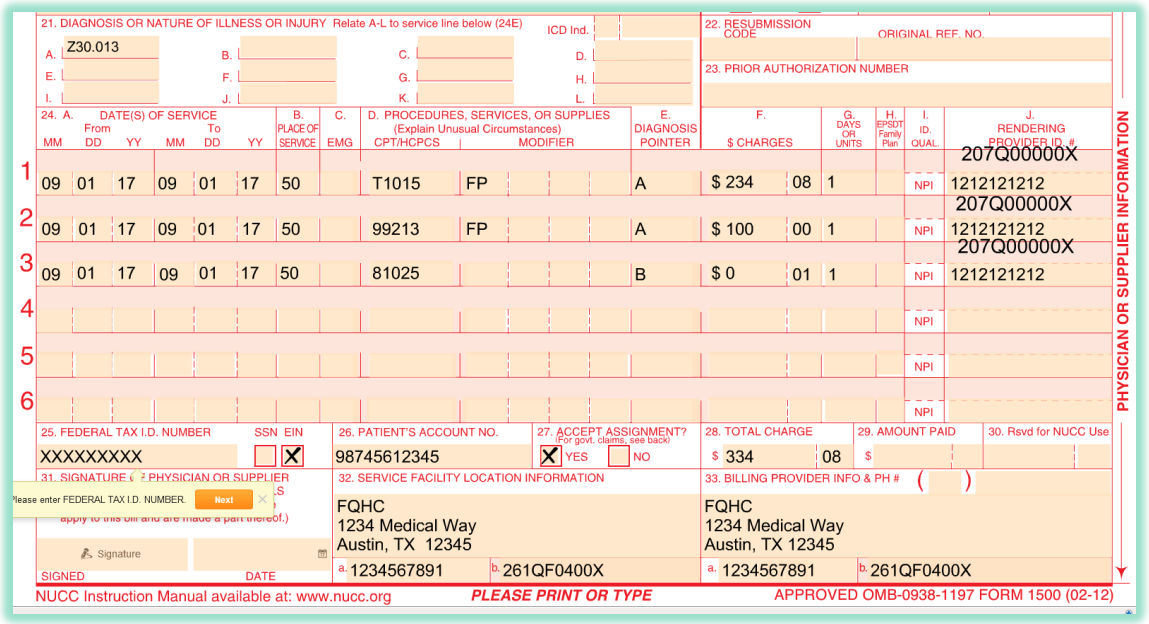
25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
XXXXXXXXX	X	987456123145	X YES NO	$ 800 01	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
ase enter FEDERAL TAX I.D. NUMBER. Next apply to this bill and are made a part thereof.) Signature SIGNED DATE	Medical FQHC Facility 1234 Medical Way Austin, TX 12345	(888) 888-8888 Medical FQHC 1234 Medical Way Austin, TX 12345
	a. 1234567891 b. 261QF0400X	a. 1234567891 b. 261QF0400X

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

Family Planning Office Consultation-Modifier **FP** is required on the initial visit only (*Does not Apply to CHIP)**:**



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.
A. Z30.013 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	01	17	09	01	17	50		T1015	FP	A	$ 234	08	1		NPI	207Q00000X 1212121212
2	09	01	17	09	01	17	50		99213	FP	A	$ 100	00	1		NPI	207Q00000X 1212121212
3	09	01	17	09	01	17	50		81025		B	$ 0	01	1		NPI	207Q00000X 1212121212
4																NPI	
5																NPI	
6																NPI	

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Signature SIGNED DATE

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FQHC
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Austin, TX 12345
a. 1234567891 b. 261QF0400X

33. BILLING PROVIDER INFO & PH # ( )
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Austin, TX 12345
a. 1234567891 b. 261QF0400X

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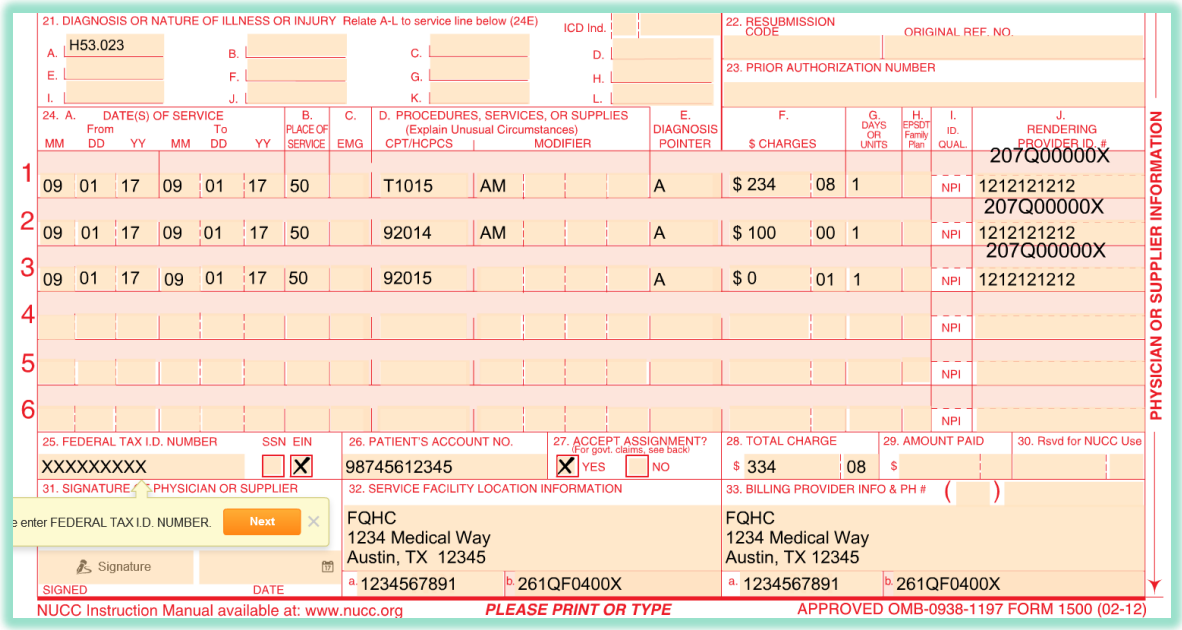
Vision Claim



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.
A. H53.023 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	01	17	09	01	17	50		T1015	AM	A	$ 234	08	1		NPI	207Q00000X 1212121212
2	09	01	17	09	01	17	50		92014	AM	A	$ 100	00	1		NPI	207Q00000X 1212121212
3	09	01	17	09	01	17	50		92015		A	$ 0	01	1		NPI	207Q00000X 1212121212
4																NPI	
5																NPI	
6																NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: XXXXXXXXX [X]
26. PATIENT'S ACCOUNT NO.: 98745612345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE: $ 334 08
29. AMOUNT PAID: $
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER — e enter FEDERAL TAX I.D. NUMBER. Next
Signature SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FQHC
1234 Medical Way
Austin, TX 12345
a. 1234567891 b. 261QF0400X

33. BILLING PROVIDER INFO & PH # ( )
FQHC
1234 Medical Way
Austin, TX 12345
a. 1234567891 b. 261QF0400X

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