Prospective Payment System (PPS) Settlement Manual

Tennessee Providers

TN Division of TennCare

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TennCare Reporting Requirements

Purpose

The purpose of this manual is to provide guidance to the Federally Qualified Health Center (FQHC)[1] and Rural Health Clinic (RHC) providers in Tennessee. Additionally, this manual addresses the reporting requirements for the supplemental payment settlement requests, based on applicable law and/or other relevant guidance.

If allowable visits and revenue received by the Provider are not properly reported, the settlement payments owed to the clinic may be inflated, and could result in a possible overpayment and/or monies being owed back to TennCare. In addition, the underreporting of visits and/or overreporting of revenue received could potentially result in a possible underpayment and/or monies being owed to the clinic in some circumstances.

Background

Consistent with Section 1902(bb) of the Social Security Act and 42 U.S.C.A. § 1396a(bb), FQHCs and RHCs are entitled to receive supplemental payment for providing covered services to Medicaid-eligible individuals. In the case of FQHC and RHC services furnished through Medicaid managed care programs, state plans are required to provide for supplemental payments to FQHCs and RHCs equal to the amount or difference between the payment under the supplemental reimbursement methodology and the payment provided under the managed care contract. The purpose of this provision is to ensure that FQHCs and RHCs receive their supplemental payment after accounting for the payments made for services by the Managed Care companies., in light of the traditional flexibility for capitated managed care plans to set provider payment rates.[2]

In accordance with federal law, Tennessee's State Plan Amendment requires the State to make quarterly payments to the clinics, for covered FQHC/RHC services and other ambulatory services furnished, for the actual difference between all amounts paid by the Managed Care companies or third party payors on behalf of TennCare enrollees and the required supplemental reimbursement amount.

In order to ensure the State is compliant with federal law and its State Plan Amendment, FQHC/RHC providers should report all such visits and payments/revenue received, as further outlined in these sections below.

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1 For purposes of this manual, Federally Qualified Health Centers or FQHCs is also meant to refer to Federally Qualified Health Center Look-Alikes or FQHCLAs.

2 See also https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/SMD16006.pdf

A. All Claims Must Be Submitted to the TennCare MCO for Payment

Before reporting any visits and revenue on the PPS settlement requests, all claims must be submitted to and deemed "paid" by the TennCare Managed Care Organization (MCO). This is to ensure that all such claims are for services covered under the managed care contract and entitled to reimbursement by TennCare. Therefore, only paid claims, including when the MCO pays $0.00 on the claim, will be considered for reimbursement for PPS settlement.

B. Visits to be Reported on the Settlement Requests

1. What Constitutes a Visit

Consistent with the federal regulations found at 42 C.F.R. § 405.2463 and 42 C.F.R. § 440.20(b)-(c), a visit eligible for settlement under this program must meet the following definition: A visit is a medically-necessary face-to-face[3] medical, mental, or qualified preventive health encounter during which one or more qualified FQHC or RHC covered services are furnished. The encounter must be between the patient and one of the following qualifying providers:

- Physician
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)
- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist (MFT) (effective January 1, 2024)
- Mental Health Counselor (MHC) (effective January 1, 2024)
- Certified Provider for Diabetes Self-management training/medical nutrition therapy (DSMT/MNT)
- Dentist (DMD, DDS)
- Registered Dental Hygienist (RDH)
- Optometrist (OD)
- Pharmacist (Pharm)

Per this definition, a nurse only encounter (e.g. procedure code 99211), is not deemed a visit eligible for settlement under this program. Qualifying providers must be registered with TennCare and credentialed with the TennCare member's

3 Please note that TennCare's MCOs are currently in compliance with state law regarding payment for services provided via telehealth in the same manner as face-to-face interactions. See TennCare memo dated June 21, 2022 https://www.tn.gov/content/dam/tn/tenncare/documents/MemoToTennCareProvidersTele-health6212022.pdf

MCO for the visit to be eligible for supplemental reimbursement.

2. Location of the Visit

To be eligible for settlement, the visit must occur in an outpatient setting. This can include the clinic or center itself, the patient's place of residence or other institution used as a patient's home, and a nursing and/or skilled nursing facility. This also includes hospice attending physician services furnished during a hospice election. Such qualifying visits, and payments received by the FQHC/RHC on the behalf of the TennCare enrollee, must be reported on the settlement requests, regardless of the location.

3. Hospital Visits

Pursuant to 42 C.F.R. § 405.2411(b)(4) and guidance from the Centers for Medicare & Medicaid Services (CMS), FQHC and RHC visits cannot take place at an inpatient or outpatient hospital department, including a critical access hospital. Therefore, post-operative encounters within the global billing period which take place at a hospital FQHC/RHC are not eligible for settlement under this program.

Please note that this does not apply to maternity visits, global deliveries, sterilization, and/or other surgical OB/GYN services which are inclusive of the global bundled maternity payment and usually occur at a hospital. Because the services which fall under the global bundled payment involve both outpatient and inpatient care, the entirety of this care will qualify as a visit. Any newborn encounter which involves only inpatient care will not qualify as an FQHC or RHC visit and is not eligible for settlement. See Section F of this manual for more information.

4. Multiple Visits on the Same Day and/or Time of Service

Generally, encounters with more than one health professional, and/or multiple encounters with the same health professional, that take place on the same day and at a single location, will constitute a single visit. However, pursuant to the federal Medicaid regulation found at 42 C.F.R. § 447.371 and guidance previously provided by TennCare, it is permissible to bill for more than one visit on the same day and/or time of service in the following circumstances:

1. Where the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day;
2. Where the patient has a medical visit, a behavioral health visit, dental visit, or optometry visit on the same day; or
3. Where the patient, under the age of 18, has a sick visit and an annual/well visit on the same day and time.

This is also consistent with the federal Medicare regulation found at 42 C.F.R. § 405.2463(c)(1). However, the exception listed therein related to an initial preventive physical exam (IPPE) is a Medicare preventative visit and is not entitled to a PPS settlement payment under this program.

5. CPT Code List for Eligible Visits

Effective October 1, 2023, TennCare has adopted a published list of CPT codes that qualify as reimbursable visits. To be eligible for payment, services billed on at least one of the claim lines must also meet the criteria for an eligible visit in this manual. The list of eligible CPT codes will be updated regularly and can be found on the TennCare website at the following link: https://www.tn.gov/tenncare/reimbursement-information-for-rhc-and-fqhc-providers.html. To request the addition of a CPT or HCPCS code to the list, please contact the Comptroller's office, who will work with TennCare to review the code.

6. Visits Performed Via Telehealth

Visits performed via telehealth are considered a face-to-face visit eligible for supplemental reimbursement provided the following criteria is met:

1. The telehealth visit otherwise meets all other necessary criteria to be considered a reimbursable visit under the PPS settlement program, including having an associated paid claim by the MCO as outlined under Section A of this manual; and
2. Encounters in which the clinic solely serves as an originating site for a telehealth encounter are not considered an eligible visit; and
3. The telehealth visit meets the definition of "provider-based telemedicine" as defined in T.C.A. § 56-7-1003(a)(6)(A).

Pursuant to T.C.A. § 56-7-1003(a)(6)(C), audio-only telehealth visits will be considered reimbursable under the PPS settlement program only when all other means for a telehealth visit are unavailable.

C. Payments to be Reported on the Supplemental Settlement Requests

The State will make quarterly payments to the FQHC/RHC for the difference between the Medicaid PPS reimbursable costs and all amounts paid on behalf of TennCare enrollees by the Managed Care companies or other third party payors. Therefore, all payments, as specified below, must be reported on the settlement requests that are submitted to the Comptroller of the Treasury's Office.

1. Revenue for Core Services

When reporting revenue on the supplemental payment settlement requests, FQHC/RHC providers must include all payments received for the provision of core services. Such core services can include, but are not limited to: office visits, nursing home visits, maternity visits, and behavioral health visits when they are a part of the scope of the services approved by the State. See TennCare memo dated March 31, 2022.

2. Revenue for Ancillary Services

When reporting revenue on the supplemental payment settlement requests, FQHC/RHC providers must include all payments resulting from the provision of ancillary services, which may be paid on a claim separately. Such ancillary services, which may result in additional payments to the clinic/provider, include, but are not limited to: X-Rays, labs, tests, injections, and nurse-only encounters. Additionally, these payments must be reported, even if there is no "PPS visit" associated with the service. For example if the patient was to come the next day for an x-ray the payment received for that x-ray must be included in the reported revenues for that quarter.

3. Revenue from Commercial Insurance & Patient Liability

All payments reported on the supplemental payment settlement requests, on behalf of the TennCare enrollee, must include the MCO's payments, all third-party liability payments, and all patient liability payments. Typically, Medicaid is a payer of last resort. So, if another insurer or payer has correctly paid for medical costs incurred by a TennCare enrollee, those payments must still be reported on the supplemental payment settlement requests. For example, when a TennCare enrollee has other primary insurance, FQHC/RHC providers must report the monies the primary insurer paid and any additional monies the MCO has paid, for purposes of determining the appropriate settlement amount. Additionally, where the MCO pays, or will pay, $0.00 because the primary insurer's contracted rate for that service is higher than the rate paid by TennCare, providers are still required to submit such claims to the MCO and must still report the visit and any resulting payments on their settlement requests.

4. Revenue from Capitation Arrangement (where applicable)

Capitation is a payment arrangement or agreement between health care providers and the MCO, where the MCO pays a set amount for each covered person assigned to the provider per period. The amount is paid to the provider whether or not the covered person actually seeks care. Such revenues must be reported on the supplemental payment settlement requests even if the enrollee has not had a visit in that reporting period. The provider should only report a visit, however, if the

enrollee actually receives services in the relevant period.

D. Where to Report Payments and Visits on the Settlement Requests

Providers must report any payments received on behalf of TennCare enrollees and any visits **in the quarter in which the services occurred, and not the quarter the service was paid**. For any capitation payments received by the MCO, providers must report those payments in the quarter for which the payment applies.

Where necessary, providers can amend prior quarters when they submit their quarterly request, if they have had additional payments or recoupments that affect that quarter with a prior date of service. Amendments are limited to twenty-four (24) months from the date of the visit being amended. The Comptroller of the Treasury's Office will send a letter amending the prior quarters, as well as a letter for the current quarter the provider is submitting.

1. How to Report Maternity Payments and Visits

Following the guidance as outlined above, maternity visits must be reported on the settlement request in the quarter in which services were rendered for that visit. However, because maternity claims are generally paid by the MCOs as a global bundled payment, the actual payment for such visits will only occur after the pregnancy has ended.

Once the payment is received, providers will need to **report the global payment in the quarter in which the pregnancy ended**. Providers must amend settlement requests for prior quarters so as to **report the visit in the quarter in which that visit occurred.** In this way, the visits will be accurately reported in the quarters in which they occurred, but all payments are reported in the quarter which the pregnancy ended.

E. PPS Reporting Requirements for Certain Provider or Service Types

1. BESMART Providers

The Buprenorphine Enhanced Supportive Medication Assisted Recovery and Treatment (BESMART) program was developed in 2019, with a focus on contracting with high quality medication assisted treatment (MAT) providers in order to provide comprehensive care to TennCare members with opioid use disorder.[4] The

4 For more information on the BESMART program, see https://www.tn.gov/tenncare/tenn-care-s-opioid-strategy/office-based-buprenorphine-treatment.html.

BESMART program is a specialized provider sub-network, with billing codes that are separate and distinct from the standard billing codes. Likewise, the respective payment amounts are also individually contracted under the prescriber's BESMART contract, separate and apart from the standard Fee for Service (FFS) contract. Payments for the BESMART program are based on the State's overall opioid strategy and are not considered normal MCO-contracted provider rates. To ensure that FQHC/RHC BESMART providers are appropriately incentivized and reimbursed for delivering this critical service to Tennesseans, effective January 1, 2021, any visits and/or revenue received as part of the BESMART program and its billing codes will be carved out from the PPS settlement process and should not be reported on the PPS settlement requests.[5] Providers may still bill the TennCare MCO to receive payment.

Examples of such historical BMAT and current BESMART billing codes that will be carved out of the PPS settlement process include, but are not limited to:

WELLPOINT (formerly AMERIGROUP) and BLUECARE

Year	Buprenorphine MAT Billing codes only (do not need the descriptions)
2021	H0014HG, H0016HG, H0033HG
2022	H0014HG, H0016HG, H0033HG

UNITED HEALTHCARE

Year	Buprenorphine MAT Billing codes only (do not need the descriptions)
2021	H0047 with U1, U2 and U3 Modifiers H0014, H0014 -U1, H0016 & H0033
2022	H0014, H0014 -U1, H0016 & H0033

2. Long-Acting Reversible Contraception (LARC) Devices

Due the high cost of LARC devices, effective October 1, 2023, any visits, devices, and/or revenue received specifically related to the implant insertion of LARC devices **will be carved out** from the PPS settlement process and should not be reported on PPS settlement requests. Providers may still bill the TennCare MCO to receive payment.

5 Please note that this is meant to only address how such codes will be utilized for purposes of PPS settlement and reimbursement. Such codes can still be utilized by FQHC/RHC BESMART providers for traditional FFS reimbursement.

3. Dentures

Due to the high costs of dentures, effective October 1, 2023, any visits and/or revenue received related to the provision of dentures, including partial dentures, **will be carved out** from the PPS settlement process and should not be reported on PPS settlement requests. Providers may still bill the TennCare Dental Benefits Manager to receive payment.

F. Claims Requirements for Multi-Site Clinics

Providers who have multiple locations are responsible for ensuring CMS-1500 Field 32 or 837p Loop 2420C contains the specific clinic site's zip+4. As each location may have a different rate, this information is necessary for the calculation of appropriate payments. Claims without a valid zip+4 are not eligible for a supplemental payment settlement.

G. Payments and Visits to be Excluded from the Settlement Requests

1. Clinics must exclude any claims that have been denied by the TennCare MCO from the PPS settlement requests.
2. Clinics must exclude any claims not filed with the TennCare MCO from the PPS settlement requests.
3. Clinics must exclude any payments and visits received on the behalf of dual enrollees. For purposes of this program, dual enrollees are individuals enrolled in both Medicaid and Medicare Part B (or any Medicare-approved plan which includes Medicare Part B, such as Medicare Advantage). Such dual enrollees will have their visits covered under Medicare and are not eligible for settlement under the Medicaid program. Dental services for individuals with no dental coverage through Medicare Part B or a Medicare Advantage Plan are eligible for supplemental payment settlement.[6]
4. Clinics must exclude Patient-Centered Medical Homes (PCMH) payments, as the intended benefit of the payments are based on quality and efficiency performance and not for settlement under this program. *See* Patient-Centered Medical Homes (PCMH) (tn.gov).
5. Clinics must exclude the retroactive temporary payment increases to primary care providers, as the intended benefit of the payments are in response to the COVID-19 crisis and not for settlement under this program. *See* TennCare memo dated December 7, 2020.
6. Clinics must exclude the revenue received for vaccine administration fees with a date of service **on or after January 1, 2021**. *See* TennCare memo dated May 11, 2021.

6 For a more detailed and exhaustive list of the choices for Medicare coverage and what they cover, see https://www.medicare.gov/what-medicare-covers.

7. With the exception of pregnancy related F codes that count as a visit (e.g. codes 0501F, 0502F, and 0503F), clinics must exclude the revenue received as incentive payments for category II F codes with a date of service **on or after October 1, 2021**. *See* TennCare memo dated December 7, 2021.

8. With the exception of the maternity visits, deliveries, and/or other OBGYN services which make up the bundled global maternity payment, effective January 1, 2022, clinics must exclude the visits and the revenue which take place at an inpatient or outpatient hospital department, including a critical access hospital, as they are not eligible for settlement under this program. See TennCare memo dated December 30, 2021. *See also* 42 C.F.R . § 405.2411(b)(4).

9. Clinics must exclude the revenue received for COVID-19 vaccine counseling, **effective March 15, 2022**, as such revenue is reimbursed outside of the PPS rate and settlement program. *See* TennCare memo dated February 25, 2022.

10. Clinics must **separately report** any visits and payments received on behalf of CoverKids enrollees. Similar to Medicaid, CoverKids[7] is jointly financed and administered by the federal and state governments. However, the CoverKids program is a federal program distinct and separate from the TennCare program. While the process for submitting invoices and receiving quarterly settlements is similar to TennCare's quarterly reimbursement, due to the distinctly allotted federal funding, CoverKids visits and payments must be separately reported and paid. As such, FQHCs and RHCs should submit a separate quarterly invoice to the Comptroller of the Treasury's Office that contains the number of visits for CoverKids services and amounts received from the MCOs, third parties, and patients for those services.

11. Clinics must exclude visits for all group services in supplemental payment settlement requests. These services are still eligible for payment from the MCOs.

12. Clinics must exclude visits for certain screenings that do not qualify as a separate, eligible visit. To be considered a reimbursable visit eligible for settlement under the PPS program, the screening must (1) meet the criteria for a reimbursable visit under Section B of this manual and (2) involve an allowable CPT code, other than the code for the screen itself, as enumerated in the TennCare CPT code list found here: https://www.tn.gov/tenncare/reimbursement-information-for-rhc-and-fqhc-providers.html.

7 The CoverKids program is Tennessee's Children's Health Insurance Program (CHIP), and is authorized by Title XXI of the Social Security Act. CoverKids is available to children under the age of 19 and pregnant women, who are not eligible for TennCare Medicaid.