Encounter Services

An encounter rate is paid for services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers. A clinic's encounter rate covers the beneficiary's visit to the clinic, including all services and supplies (drugs and biologicals that are not usually self-administered by the patient) furnished as an incident to a professional service. When services, supplies, drugs or biologicals are included in the clinic's encounter rates, the clinic cannot send the beneficiary to another provider that will bill Medicaid for the covered service, supply, drug or biological.

When a beneficiary sees more than one provider type (medical, dental, optometry, or mental health) at the same Federally Qualified Health Center on the same date the clinic will be reimbursed as charted below. The exception is a case in which the patient, subsequent to the first encounter, suffers illness or injury requiring an additional diagnosis or treatment. For example, a beneficiary has a visit in the morning with a physician for a medical illness and has to return in the afternoon due to an injury which resulted in a lacerated hand. In such case, a medical encounter is paid for both visits. If the beneficiary receives an EPSDT screening only or an EPSDT screening with a medical visit on the same date, only one (1) medical encounter is paid to the clinic.

Provider Type	Encounter Allowance
Physician, Nurse Practitioner, and/or Nurse Midwife	Only one medical encounter per day
Dentist	Only one dental encounter per day
Optometrist	Only one optometry encounter per day
Clinical Psychologist and/or Clinical Social Worker	Only one mental health encounter per day

Examples are:

Service	Maximum Daily Encounter Allowance
EPSDT screening in the morning, child later becomes ill on same date, and is examined by physician in the afternoon	Two (2) medical encounters
EPSDT screening and covered dental services on same date	One (1) medical encounter and one (1) dental encounter
Physician examination for an illness and EPSDT screening during same visit	One (1) medical encounter
Exam by optometrist and dentist on same date	One(1) optometry encounter and one (1) dental encounter
Physician visit and clinical psychologist visit on same date	One (1) medical encounter and one (1) mental health encounter

The maximum number of encounters that can be paid to the same FQHC for the same beneficiary on the same date is four (4). The only exception is an instance where the beneficiary has visits with all the core service types on the same day, and in addition, the beneficiary has to return to the clinic for an injury or illness requiring additional diagnosis or treatment. In such case, the FQHC may be paid another medical encounter.

For an encounter to be paid, the service must be covered in accordance with the policies of the Mississippi Medicaid Program. All limitations and exclusions are applicable. If a service requires prior authorization, the provider must satisfy the prior authorization requirements.

Claims submitted to the fiscal agent for the same beneficiary will pay one encounter rate for each date of service and provider type (medical, dental, optometry, or mental health). A separate claim must be submitted for medical, dental, optometry, or mental health services. Claims for visits requiring additional diagnosis or treatment must be submitted to the fiscal agent as a paper claim with documentation justifying the medical necessity for the additional visit on the same date. Providers may refer to the DOM website at www.medicaid.ms.gov for a list of procedure codes which generate an encounter.

Approved Places of Service

All ambulatory services performed by a center employee or contractual worker for a center patient must be billed as an FQHC claim. This includes services provided in the clinic, skilled nursing facility, nursing facility or other institution used as a patient's home. The program will pay for visits at multiple places of service for a patient. Services performed for clinic patients by an outside lab should be billed to Medicaid by the outside lab. However, claims for in-house lab services must be billed with the same place of service code as the visit. In-house lab services are covered in the visit payment.

Federally Qualified Health Center services are not covered when performed in a hospital (inpatient or outpatient). Physicians employed by an FQHC and rendering services to Medicaid beneficiaries in a hospital will be reimbursed fee-for-service. The physician must obtain a provider number from the Division of Medicaid and bill using the CMS 1500 claim form.

Fee-for-Service

No services (same or separate dates) will be reimbursed to the clinic at a fee-for-service rate. All ambulatory services provided in an FQHC will be reimbursed an encounter rate on a per visit basis.

Drugs Purchased Under a Veterans Health Care Act Discount Agreement

The Veterans Health Care Act applies to FQHCs and allows centers to sign an agreement with drug companies to purchase drugs at a discount price. DOM is not allowed to file for a rebate on drugs purchased through a discount agreement. Therefore, all drugs purchased at a discounted price through a discount agreement must not be billed through the Medicaid pharmacy program. The reimbursement for the drugs is included in the encounter rate.

Obstetrical

Providers must utilize CPT evaluation and management codes 99201 through 99215, 59425, and 59426 to bill antepartum visits as listed below.

(A) Providers must bill CPT codes in the 99201 through 99215 range for antepartum visits 1 or 2 or 3. Bill one code per visit.

(B) Providers must bill CPT code 59425 for antepartum visits 4, 5, or 6. Bill one code per visit.

(C) Providers must bill CPT code 59426 for antepartum visits 7 or over. Bill one code per visit.

The number of the antepartum visit is defined as to the number of the visit(s) that the beneficiary has been to one physician. For example, if a beneficiary goes to Dr. A for antepartum visit 1, 2, 3, and 4 and then moves and goes to Dr. B, Dr. A will bill the appropriate evaluation and management code for each antepartum visit 1 or 2 or 3 and CPT code 59425 for antepartum visit 4. Dr. B will then bill for his antepartum visits starting with antepartum visit number 1, etc.

CPT codes 59410, 59515, 59614, and 59622 will be used to reimburse deliveries and postpartum care as of October 1, 2003. The postpartum care is inclusive of both hospital and office visits following vaginal or cesarean section deliveries. These codes must be billed under the individual physician's Medicaid provider number.

CPT code 59430 can only be billed for postpartum visits when the clinic physician was not the delivering physician.

Modifier TH identifies "obstetrical treatment/services, prenatal and postpartum" and must be reported with each code for antepartum visits and deliveries and postpartum care. The Division of Medicaid will utilize this modifier to track data and to bypass the physician visit limitation of twelve (12). Antepartum office visits will not be applied to this limitation.

Refer to the Maternity, Section 38.0 of the Provider Policy Manual.

Subdermal Implant

The cost of a subdermal implant is included in the encounter rate and will not be reimbursed separately.