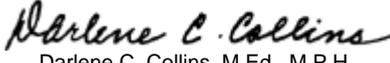


	<b>MEDICAL ASSISTANCE BULLETIN</b> <b>COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE</b>	
	<b>SUBJECT</b> Provider Billing Information for the Family Care Network (FCN) Program	<b>BY</b>  Darlene C. Collins, M.Ed., M.P.H. Deputy Secretary for Medical Assistance Programs
<b>NUMBER:</b>	99-96-04	
<b>ISSUE DATE:</b>	May 23, 1996	
<b>EFFECTIVE DATE:</b>	May 23, 1996	

**PURPOSE:**

The purpose of this bulletin is to notify all providers of the billing process for recipients enrolled in the FCN and to emphasize key points of the FCN program.

**SCOPE:**

This bulletin applies to all providers enrolled in the Medical Assistance Program.

**BACKGROUND:**

On October 14, 1993, the Health Care Financing Administration (HCFA) approved the Department's request for a waiver to implement a fee-for-service primary care case management program for MA recipients under age 21 in 60 counties. The initial phase-in of the FCN began in York County in February 1994. By July 1, 1995, most MA recipients under age 21 in 57 counties of the Commonwealth were assigned to a primary care case manager (PCCM) who is responsible for providing most medical services to the recipients assigned to his/her panel. MA providers who may enroll as case managers in the FCN are physicians who provide primary health care, independent medical clinics, hospital outpatient clinics, rural health clinics and federally qualified health centers. Please note: At this time, the FCN has not been implemented in Cumberland, Mifflin and Monroe Counties.

Medical Assistance Bulletin 99-94-06 (effective April 1, 1994) and Remittance Advice Alerts issued with cycles 12 & 13 (dated September 11, 1995) also address the FCN Program.

**PROCEDURE:**

Verifying Recipient Enrollment

Before treating a recipient, the provider should verify the recipient's eligibility through the Eligibility Verification System (EVS). The FCN membership card is not proof of eligibility.

If an EVS inquiry is made through a Point-of-Sale device or personal computer and the recipient is in the FCN, the response will include the name and phone number of the recipient's PCCM.

If an EVS inquiry is made by phone and the recipient is in the FCN, the response will be "Medical Assistance Benefits for this recipient are provided through the Family Care Network. Most services require coordination with or referral by the recipient's PCCM. Please contact the plan for coverage information. The plan's hotline number is 1-800-543-7633." This is the phone number for Automated Health Systems, Inc (AHSI), the Department's program contractor. AHSI will provide you with the name and telephone number of the assigned PCCM.

If an EVS inquiry states that the recipient is not enrolled in the FCN, the provider should follow normal procedures for treating and billing for MA recipients.

Determining if a PCCM Referral is Needed

Services provided to clients enrolled in the Network are subject to all existing MA fee-for-service rules and regulations. The Department will continue to include them in Quality Assurance reviews. Providers will still be required to obtain prior

authorization where applicable. Co-payments will still apply as appropriate.

The following services do not need referral from the Network provider:

- Audiology Services;
- Emergency Services;
- Ambulance Services
- Inpatient Hospital Care;
- Inpatient Residential Treatment;
- Prescription Drugs or Medical Equipment;
- Dental Services;
- Eye Exams and Glasses;
- Family Planning Services;
- Obstetrical/Gynecological Services;
- Mental Health Services;
- Drug and Alcohol Treatment;
- Nursing Home or ICF/MR Care;
- Diagnostic Services; or,
- Laboratory Services.

Services provided in an inpatient hospital (03), a nursing facility (08), a Short Procedure Unit/Ambulatory Surgical Center (12) or a State Mental Retardation Center (15) are exempt from needing a PCCM referral. Billing the Department for these services is done as a regular fee-for-service claim.

Services provided on an emergency basis do not require a PCCM referral and should be billed as a regular fee-for-service claim. MA Bulletin 01-95-19 notified providers that effective October 1, 1995, the Department will discontinue payments to hospitals and physicians for non-emergency use of hospital emergency rooms. Recipients enrolled in HealthPASS, an HMO, or a PCCM program such as FCN should seek non-emergency care from their primary care provider. If a recipient enrolled in one of these programs presents him/herself to the emergency room for non-emergency care, the recipient should be referred back to the assigned PCCM to arrange for treatment.

Services provided with a visit code 08, Juvenile Detention Center, do not need a PCCM referral.

The following types of service are exempt from a PCCM referral and are processed as regular fee-for-service claims: AF, AG, AL, AM, AR, AS, AU, AY, AZ, DC, EI, ES, FP, HB, LT, PS, PT, RD, SC, WA, 9B, 9S, 25, 30, 40, 54, 57, 70, 86, 90 (w/procedure codes W0650 through W0654) and 95. Any need for prior authorization remains.

Ophthalmologists may provide medical examinations and evaluations with procedure codes 92002, 92004, 92012, 92014, 92015, 92018, 92019, and 92020 without a PCCM referral.

The following MA provider types should check with the network provider before providing other services to coordinate care and arrange for a referral if appropriate:

PROVIDER TYPE CODE	DESCRIPTION
01	Physician (including specialists)
04	Podiatrist
07	Chiropractor
10	Independent Med/Surg Clinic
11	General Hospital Outpatient Clinic
23	Home Health Agency
26	Rural Health Clinics/Federally Qualified Health Centers
43	Physical Therapist
49	Certified Nurse Practitioners

All other services will be provided by the assigned PCCM or through a referral from the PCCM.

Referring PCCMs are reminded to use the FCN RFS-1 if a referral is made. These forms are available from AHSI, 1-800-892-1028.

If Provider is the Assigned PCCM

If the recipient is in the provider's FCN panel, services are provided and billed as they were prior to the FCN implementation.

If a group is enrolled as the PCCM and an individual provider within the group is invoicing for services, the group's MA provider number must be indicated as the referring PCCM in item 24 of the Physician's Invoice (MA 319). For providers using the HCFA 1500 invoice, the PCCM's MA provider number must be entered in item 17a.

If the assigned provider needs to refer the recipient to another provider, then the PCCM schedules the appointment and completes the FCN RFS-1 form which indicates the appointment time and place and MAID number of the referring PCCM. The white copy is given to the recipient and must be taken to the appointment to provide necessary authorization for the referral specialist. The yellow copy is sent to AHSI and is used for tracking purposes. The pink copy is filed with the child's record. (NOTE: The AHSI Referral Department is responsible for determining if appointments are kept. Please cooperate with them when they call for verification.)

The referral may be used to cover the length of the anticipated treatment up to a period of 6 months. If the PCCM reviews the case and feels further treatment is indicated, a new referral must be made.

If Provider is NOT the Assigned PCCM

If the provider performing the service is not the assigned PCCM, a referral is needed for services not listed in the section "Determining if a PCCM Referral Is Needed." The referring PCCM gives the recipient a FCN RFS-1 which indicates the appointment time and place and the referring PCCM's name and MA provider number. When billing, the PCCM's MA provider number is entered in item 24 on the Physician's Invoice (MA 319). For providers submitting the HCFA-1500, the PCCM's number must be entered in item 17a. The claim is then submitted to DPW as a regular fee-for-service claim.

If the type of service requires a PCCM referral, and the referring PCCM's MA provider number is not in block 24, the claim will be rejected.

General Reminder to Providers

Whenever a provider has a question regarding invoice completion or billing procedures and policy, the provider should try to resolve the question by using the provider handbook. If the question cannot be resolved by using the handbook, the provider should direct the inquiry to the appropriate toll-free number or address for their provider type (See MA Bulletin 99-92-08, issued December 30, 1992).

Whenever a provider has a question regarding pends, rejections or inappropriate payments, the provider should try to resolve the question by using the provider handbook, and the Automated Voice Response System. If the question cannot be resolved by these methods, the provider should call 1-800-678-3337. (See MA Bulletin 99-92-08).

Providers interested in enrolling as a PCCM in the FCN should contact AHSI for further information at the following address:

Automated Health Systems, Incorporated  
300 Arcadia Court  
9370 McKnight Road  
Pittsburgh, PA 15237

1-800-892-1028 OR 412-367-3030

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

Call the appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at [www.dpw.state.pa.us/omap](http://www.dpw.state.pa.us/omap).