

DATE:	March 31, 2022	Number: M-220
TO:	All BMC HealthNet Plan Providers	
FROM:	BMC HealthNet Plan	
SUBJECT:	CHC/FQHC T1015 Billing Requirements and Claims Editing	
PRODUCT:	🛛 MassHealth 🖾 Qualified Health Plans 🗆 Senior Car	e Options

T1015 Billing Requirements and Claims Editing

Effective June 1, 2022, the Plan will edit Community Health Center (CHC) and Federally Qualified Health Center (FQHC) claims according to the following criteria below.

Claims for the all-inclusive clinic visit must be billed with T1015 along with the qualifying evaluation and management CPT/HCPCS code that identifies the service provided. Any claim billed for T1015 without the qualifying evaluation and management CPT/HCPCS code will be denied. Qualifying evaluation and management visit codes to be reported along with all-inclusive code T1015 are 99202-99205, 99211-99215, 99386, 99387, 99396, 99397 and both 99385 and 99395 for the ages of 21-39 years.

The Plan will reimburse HCPCS T1015 once per day per member. Any visit in which a member is seen by more than one healthcare professional for the same medical problem or general purpose, must be submitted as only one visit regardless of the number of clinicians seen.

Certain provider types, as identified in the Plan's policy, are prohibited from billing the all-inclusive clinic visit T1015 and instead must bill on a fee-for-service basis with the appropriate CPT/HCPCS codes. Claims billed with T1015 will be denied for the following provider types: acupuncturists, podiatrists, nutritionist/dieticians and optometrists.

Providers can reference BMC HealthNet Plan's reimbursement policy, *Community Health Center and Federally Qualified Health Center, 2112* for more information.

Questions?

If you have any questions about this Network Notification, please contact your dedicated Provider Relations Consultant or call the Provider Line at 1-888-566-0008. All BMC HealthNet Plan <u>Network Notifications and Reimbursement Policies</u> are available online at bmchp.org.