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21.1 General

21.1.1 Description

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are providers that meet the criteria of an RHC, FQHC, or FQHC look-alike (referred to as FQHC for the remainder of this chapter) as defined by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). They are differentiated from other Fee-for-service Medicaid providers in several ways:

- They must receive a designation from the federal government as an FQHC/RHC;
- They have a unique definition of services that qualify as FQHC/RHC services;
- They are reimbursed using a Prospective Payment System (PPS) methodology; and
- They have a unique billing methodology from other Medicaid providers.

21.1.2 Becoming a Medicaid Provider in Hawaii

In order to become a Fee-for-service provider for Medicaid in Hawaii, providers must follow the instructions and meet the requirements listed in Chapter 3 of this manual. Payments may not be made to any provider prior to the date of approval of a valid provider agreement.

21.1.3 Receiving Designation as an FQHC/RHC

In order to receive designation as an FQHC/RHC under the Hawaii Medicaid program, providers must meet the requirements as listed in 42 CFR 405.2401 (b). This includes receiving a grant under Sections 329, 330 or 340 of the Public Health Services Act or receiving funding from a recipient of a grant.

In addition, other non-profit organizations that are determined by the Secretary of Health and Human Services to meet the requirements for receiving such a grant may qualify as an FQHC Look-alike provider. Such determination is made based on the recommendation of the Public Health Service.

In addition to the Provider Information Form (DHS 1139), providers wishing to receive the designation of an FQHC/RHC in the Hawaii Medicaid program must submit a copy of their

grant letter or other documentation from the Department of Health and Human Services (DHHS) showing eligibility. If a provider does not submit this information, they will not receive the designation of FQHC/RHC.

21.2 FQHC Services

21.2.1 Covered Services

Covered items and services means health care services or items which are:

- Within the legal authority of an FQHC/RHC to deliver, as defined in Section 1905 of the Social Security Act;
- Actually provided by the FQHC/RHC, either directly or under arrangements;
- Covered benefits under the Medicaid program, as defined in Section 4231 of the State Medicaid Manual and the Hawaii Medicaid State Plan;
- Provided to a recipient eligible for Medicaid benefits;
- Delivered exclusively by health care professionals (a physician, a physician's assistant, a nurse practitioner, a nurse midwife, a clinical social worker or a clinical psychologist) and other persons acting within the lawful scope of their license or certificate to provide services.

Determination of covered items and services are also subject to requirements generally or legally imposed on payment for benefits under the Medicaid program.

21.2.2 Definition of Core Services

Core services include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services.

21.2.3 Delivery Sites for Core Services

Core services can be provided at the provider's practice site, a hospital emergency room, in an inpatient setting, at the patient's place of residence (including nursing homes), or at another medical facility. All care provided at these locations by staff employed by an FQHC or contract provider under arrangements with an FQHC are considered core services and are all reimbursed at the FQHC/RHC's PPS rate.

21.2.4 Dental Services

Dental services are those provided by a core service provider including dentists and dental hygienists. A separate dental encounter rate covers the recipient's visit to the center, including all services and supplies incidental to that visit.

21.2.5 Excluded Services

Please refer to Appendix 1 of this manual for a list of services excluded from coverage under Hawaii Medicaid.

21.3 Reimbursement

21.3.1 Reimbursement for Services

In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, reimbursement is provided for "core" services and other ambulatory services at a prospective payment rate (PPS) per encounter.

21.3.2 Establishment of PPS Rate

The rates will be calculated on a per encounter basis and be equal to 100 percent of the average of the FQHC/RHC's reasonable cost of providing Medicaid-covered services including any other ambulatory services cost during Fiscal Year (FY) 1999 and FY 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during a fiscal year. Cost reports for the FQHC's FY 1999 and FY2000 periods will be used to establish the baseline rate for each FQHC effective January 1, 2001. The baseline rate will be calculated by dividing the sum of the total reasonable cost of providing Medicaid covered services during FY1999 and FY2000 by the total of all center visits during the two fiscal years. Until the baseline rates are established, FQHCs will be paid their interim rate effective December 31, 2000. When the baseline rates are established, they will be paid retroactive to January 1, 2001.

The baseline rates effective January 1, 2001, will be adjusted by the Medicare Economic Index (MEI) effective for dates of service on and after January 1, 2002 based on the MEI and for changes in the FQHC/RHC's scope of services during FY01. For calendar years after 2002, the per visit rate will be calculated by adjusting the previous year's rate by the MEI for primary care, and for changes in the FQHC/RHC's scope of services during the prior calendar year.

For FQHC/RHC's qualified after FY2000, initial PPS rates will be established by reference to payments to other centers in the state offering a similar scope of service and having a similar caseload. After the initial year, PPS payments will be set using the MEI methods used for other clinics.

21.3.3 Definition of Change in Scope of Services

For purposes of this reimbursement methodology, a change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. It is the center's responsibility to recognize any changes in their scope of services and to notify the Department of these changes and to provide the department with documentation and projections of the cost and volume of the impact of the change, including a cost report reflecting the new services.

21.3.4 Supplemental Payments for Managed Care Contracts

If an FQHC/RHC provides core services pursuant to a contract between the center and a managed care entity, the State shall provide payment of a supplemental payment equal to the amount (if any) by which the amount calculated in the above paragraph exceeds the amount of the payments provided under the contract. These supplemental payments shall be made quarterly by the State and will be reconciled on an annual basis. The FQHC/RHC may be required to submit a report to the State substantiating the number of encounters and payment for services received from each managed care plan with which it contracts.

21.2 Billing

21.4.1 Billing for Services

The FQHC/RHC must bill for all services qualified as FQHC services using the Hawaii Medicaid Provider Number established for that FQHC/RHC. Additionally, the FQHC/RHC agrees to ensure that no staff or contract provider will seek separate reimbursement from the Department for specific service billable under the FQHC program. The FQHC also agrees that laboratory, radiological, and other services ordered by the FQHC staff, but provided by an organization independent of the FQHC must be billed by the provider of the service and not the FQHC.

The FQHC agrees to accept an all-inclusive payment amount for each primary medical care encounter based on the PPS rate established for that FQHC/RHC.

21.4.2 Definition of an Encounter

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services and includes the recipient's visit to the center, including all services and supplies incidental to a practitioner's services, if the services or supplies are of a type commonly furnished in a practitioner's office, commonly furnished either without charge or included in the FQHC's bill, and furnished as an incidental, although integral part of professional services.

Contacts with one or more health professionals and multiple contacts with the same health professional that take place on the same day and at a single location constitute a single

encounter. Medicaid will only pay for one encounter per day, except when one of the following conditions exist:

- (i) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or
- (ii) For FQHCs, the patient has a medical visit and an “other” health visit, such as a behavioral health visit.

Medicaid pays for a maximum of two encounters per day when the conditions in paragraphs (i) or (ii) above are met. This limitation does not include dental services. However, dental services are limited to one dental encounter per date of service.

Encounters are classified as billable or non-billable.

Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to MQD for payment through the Fiscal Agent.

Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above. Such services include, but are not limited to, weight check only or blood pressure check only. Non-billable encounters cannot be forwarded to MQD for payment.

21.4.3 Claim Forms

When billing for Medicaid services in Hawaii, FQHC/RHCs must bill using either the UB-92 (HCFA 1450) for medical or “other” encounters and the ADA 1999 version 2000 form for dental encounters.

21.4.4 Coding of Claims

- UB-92 (HCFA 1450)
 - a) Provider coding of revenue, diagnosis and procedures is required for all claims.
 - b) The Type of Bill on the UB-92 should always be 73X.
 - c) The revenue code used for billing is 520 for medical or “other” encounters
 - d) In addition to the revenue code, the FQHC must also include CPT-4 Code 99212 in FL 44.

- e) The coding schemes acceptable by the Division are the ICD-9-CM (International Classification of Diseases - 9th Edition - Clinical Modification) for diagnosis and the CPT-4 (Current Procedural Terminology - 4th Edition) for procedures.
- American Dental Association (ADA) 1999 v. 2000 - Providers should follow the instructions listed in Appendix 3 of this manual for completing the ADA 1999 v. 2000 form. FQHC/RHCs should only use CDT-3 code D0120 when billing for a dental encounter.

21.4.5 Billing for Individuals who are Eligible for Medicare and Medicaid

When services are rendered to Medicaid recipients who are also eligible for Medicare, the provider must bill Medicare on the form as prescribed by the carrier processing the Medicare claim. More detailed information on billing Medicare can be found in Chapter 4 of this manual.

