



Chapter 21

Medicaid Provider Manual

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21.1 GENERAL

21.1.1 Descriptions

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are providers that meet the criteria of a FQHC or FQHC look-alike (collectively referred to as FQHC for the remainder of this chapter) or of a RHC, as defined by the United States Department of Health and Human Services (DHHS), 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; and
- They are reimbursed using a Prospective Payment System (PPS) methodology.

21.1.2 Becoming a Medicaid Provider in Hawaii

All providers rendering services in an FQHC/RHC must be licensed to perform services in the state of Hawaii. Credentialing and verification of licensing is the responsibility of the FQHC/RHC.

21.1.3 Receiving Designation as a 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 client of a grant. In addition, other non-profit organizations that are determined by the Secretary of DHHS 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 DHHS Health Resources Services Administration (HRSA). 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 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 Providers Who May Provide PPS Eligible Services

FQHC services shall be delivered exclusively by the following health care professionals who are licensed and a resident of the State of Hawaii:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Doctor of Dentistry;
- Doctor of Optometry;
- Doctor of Podiatry;
- Physician's assistant (PA);
- Nurse practitioner (advance practice registered nurse (APRN));
- Certified nurse midwife (APRN with subcategory);
- Visiting nurse (A visiting nurse is a resident of Hawaii who is a licensed registered nurse, licensed practical nurse, or licensed vocational nurse that is employed by or receives compensation for the services from an FQHC.);
- Clinical social worker;
- Clinical psychologist; or
- Licensed dietician.

Services provided by health care providers other than those listed above, even if under their supervision, are not covered.

21.2.2 Covered Services Eligible for PPS Reimbursement

To be eligible for PPS reimbursement services must be:

- Within the legal authority of an FQHC or RHC to deliver, as defined in Section 1905 of the Social Security Act as amended;
- Actually provided by the FQHC or RHC, either directly or under arrangements;
- Medicaid covered ambulatory services under the Medicaid program, as defined in the Hawaii Medicaid State Plan;
- Within the scope of services provided by the State under its fee-for-service Medicaid program and its QUEST, QUEST-ACE, QUEST-Net and QExA programs;
- Provided to a recipient eligible for Medicaid benefits;
- Delivered exclusively by the licensed health care professionals listed in section 21.2.1 who are residents of Hawaii; and
- Provided in an outpatient setting during business or after hours on the FQHC's or RHC's site. For full-benefit dual eligibles only, services may be provided at the

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patient's place of residence, which may be a skilled nursing facility, a nursing facility or other institution used as a patient's home, within the limitation noted below:

- For all inpatient and outpatient hospital services, payments are limited to State plan rates and payment methodologies.
- For all other services, payments are up to the full amount of the Medicare rate.
- For FQHC services that are covered under Medicare and Medicaid, payments will be paid first by Medicare and the difference by Medicaid, up to the State's payment limit.
- Reimbursement for outpatient services provided outside the FQHC or RHC facility site shall be limited to Qualified Medicare Beneficiary Plus (QMB Plus) and Full Benefit Dual Eligibles (FBDEs) up to the State Plan limit.

Supplies and services (including laboratory, ultrasound, and radiology) incidental to the FQHC covered services described above are included in the all-inclusive PPS rate. Services "incidental to" include services such as vaccine administration, vaccines, drugs (identified by Health Care Financing Administration Common Procedural Coding System (HCPCS) with alphas such as A, C, J, S, and Q), intrauterine devices (IUD), diagnostic studies such as bone density, mammography, ultrasound of the pregnant uterus, contrast material used in radiology, surgical trays, sutures, tongue blades, sheets, urine collection cups, etc., and foreign language and sign language interpreter services.

21.2.3 Services Not Eligible for PPS Reimbursement

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

Services covered under the State Plan but specifically excluded from FQHC PPS reimbursement include:

- Services provided by a physical therapist, occupational therapist, speech-language therapist and audiologist;
- Hospital services, including vaginal or Cesarean delivery (Global billing is not allowed); and
- Medications provide by a pharmacy that is part of the FQHC.

It is permissible for an FQHC to bill the Department or designated fiscal agent, including contracted health plan, for non-FQHC professional services provided by an employed or contracted practitioner. In such instances, the services provided by the practitioner are not considered FQHC services and are not to be considered in calculations pertaining to PPS-based payments to FQHCs for FQHC services. In such instances, the Department

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or designated fiscal agent will reimburse the FQHC on behalf of the practitioner at the rate specified for that practitioner under the State Plan or in accordance with the provider agreement with the health plan for the professional services provided to the Medicaid beneficiary.

“Facility fees” are not covered. Like Medicare, Medicaid does not recognize free standing emergency rooms. Thus, no separate “facility fee” is payable if a Medicaid recipient is seen in an FQHC’s “emergency room.” The FQHC PPS rate includes both provider and facility costs. Thus, whether an FQHC outpatient visit is for emergency treatment or non-emergency treatment, the visit is an encounter and reimbursed at the PPS rate.

Services provided under state-only funded medical assistance are not eligible for PPS reimbursement.

21.2.4 Dental Services

Dental services are those provided by a Doctor of Dentistry. A separate dental encounter reimbursement rate covers the client’s visit to the center, including all services and supplies incidental to that visit. Eligible services must meet the criteria in section 21.2.2.

21.3 REIMBURSEMENT

21.3.1 Reimbursement of Services

Federally qualified health center ("FQHC") and rural health clinic ("RHC") services shall be reimbursed on a prospective payment system ("PPS") that conforms to the requirements of section 702 of the Benefits Improvement and Protection Act of 2000 ("BIPA").

21.3.2 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. A change in cost alone will not be considered a change in scope of service.

An FQHC or RHC requesting a rate adjustment for changes in scope of service must submit data/documentation/schedules that substantiate any changes in services and the related adjustment of reasonable costs following Medicare principles of reimbursement.

Additionally, the net change in the FQHC's or RHC's per visit rates must equal or exceed 3 per cent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish baseline PPS rates, the net change of 3 percent shall be applied to the average per visit rate of all the sites of the FQHC or RHC for purposes of calculating the costs associated with a scope of service change. "Net change" shall mean the per visit change attributable to the cumulative effect of all increases or decreases for a particular fiscal year. "Fiscal year" shall be construed to reference the fiscal year of the specific FQHC or RHC under consideration.

PPS rates may be adjusted for changes in the scope of services provided by an FQHC or RHC upon submission of a written notice to the Department specifying the changes in scope of service and the reasons for those changes within 60 days of the effective date of the changes. If the written notice is greater than 60 days after the effective date of changes the Department will consider the effective date of change of scope of services to be the notification date.

21.3.3 Payments By Managed Care Contracts

Effective January 1, 2010 for QUEST and February 1, 2009 for QExA, if an FQHC/RHC provides services eligible for PPS reimbursement pursuant to a contract between the center and a QUEST/QExA Medicaid managed care entity, the managed care entity shall provide payment at the FQHC's PPS rate. If the FQHC has a new change in scope of service, the QUEST/QExA plan should continue to reimburse at the approved PPS rate until MQD revises its capitation payments to include the new rate. The MQD will adjust the FQHC's total payment based on the effective date of the new PPS rate through its reconciliation process, until capitation payments have been adjusted.

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If Medicare is the QUEST/QExA's member's primary insurer and the QUEST/QExA plan has a contract with the FQHC, after payment by Medicare, the plan should pay the difference up to the Medicaid PPS rate. If the plan does not have a contract with the FQHC, the plan should pay the difference up to the Medicare PPS rate.

21.4 BILLING

21.4.1 Billing for Services

The FQHC/RHC must bill for all services qualified as FQHC services using the National Provider Identification Number established for that FQHC/RHC (not individual ID#). Additionally, the FQHC/RHC agrees to ensure that no staff or contract provider will seek separate reimbursement from the Department for services billed by the FQHC. 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 for services eligible for such reimbursement provided to eligible recipients.

All qualified health provider services are billed according to the duration of the encounter with the patient, e.g., if a provider bills for 20 minutes under CPT code 90804, the qualified health professional is providing the service for the entire 20 minutes.

21.4.1.1 Billing on the Same Day of Services

Federally Qualified Health Centers (FQHCs)/RHCs are paid a global rate for all services performed by the FQHC/RHC staff for each encounter with a Medicaid client per day. 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 shall constitute a single encounter unless:

- i. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or
- ii. The patient makes visits for different types of services, specifically, dental, vision, or behavioral health. Medicaid shall pay for a maximum of one visit per day for each of these services in addition to one medical visit.

Medicaid pays for a maximum of three non-dental 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.

If medical, behavioral health/psychiatry, vision, and/or dental services are provided on the same day by the same FQHC/RHC, they must be submitted on different claim forms with diagnosis(es) clearly indicating the service that was provided. If the diagnosis(es) are the same for two or more revenue codes and/or two or more claims on the same date of service, only one claim line or revenue code will be paid. The FQHC PPS rates are based on one Medicaid covered service per day. Thus, additional services on the same day are allowed only when provided for unrelated medical reasons.

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PPS eligible services not considered as behavioral health, dental, or vision are considered medical, and only one medical visit per day except as described above is covered regardless of the provider type. For example, although services by a Doctor of Podiatry or Doctor of Osteopathy (with or without osteopathic manipulation) qualify as a covered medical encounter, if these are performed on the same day as a visit to a physician's assistant, APRN, or a Doctor of Medicine, only one encounter is reimbursable.

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 include the client's visit to the center, all services, and supplies incidental to a practitioner's services. Encounters also include the services or supplies that are commonly furnished in a practitioner's office, either without charge or included in the FQHC's bill, or furnished as incidental although an integral part of professional services.

Contacts with one or more health professionals whether more than one is/are qualified (PPS reimbursable) or a combination of qualified and unqualified (not PPS reimbursable) and multiple contacts with the same qualified 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 as described in 21.4.1.1.

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 for recipients in the fee-for-service Medicaid program are forwarded to MQD for payment through the Fiscal Agent. Billable encounters for recipients in a QUEST/QExA plan are sent to the plan in which the patient is enrolled.

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 should not be forwarded to MQD for payment.

Federally Qualified Health Centers**21.4.3 Claim Forms**

When billing for Medicaid services in Hawaii, FQHC/RHCs must use either the UB-04 or dental claim forms or electronically in UB-04 format.

The FQHC/RHC must submit claims for all services provided by its professional staff using its FQHC/RHC provider number. Claims for professional services are NOT payable on HCFA (CMS) 1500 forms or in 1500 format.

No more than one date of service can be submitted per UB-04 claim form per Medicaid client. Only one claim per day can be submitted for each allowable revenue code for a Medicaid covered service.

21.4.4 Coding of Claims**• UB-04**

- a) Provider coding of revenue, diagnosis and procedures is required for all claims.

- b) The Type of Bill on the UB-04 should always be 73X.

- c) The revenue code used for billing is 520 for medical or 910 and 529 for “other” encounters.

- d) In addition to the revenue code, the FQHC must also include CPT-4 Code(s).

When Medicaid is the client’s primary health care insurer, the required revenue code and linked CPT(s) are as follows:

Revenue Code	CPT Code	Usage
520	99212	All services performed in all outpatient settings including outpatient hospital emergency rooms/treatment rooms, etc. by FQHC/RCH professional staff
910	90804-90807, 90810-90811, 90847-90853, 90862	Psychotherapy (individual and group) in all outpatient settings, including medication management done on same day as psychotherapy; if done on another day use 520 revenue code with applicable HCPCS code (either 99232 or 99212). Please note that only licensed psychiatrists can use the codes with the specific description, “with medical evaluation and management services.”
520	96150-96155	Health and behavioral assessments/interventions ONLY for FQHCs and RHCs with grants to provide integrated behavioral health services.

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520	92340	Vision services and supplies (such as eye glasses) provided by FQHC/RCH ophthalmologists/optometrists. Vision services are part of the medical rate (there is no separate vision service rate established). These services will be paid at the medical PPS rate.
529	99199	All services NOT covered by Medicaid. If an FQHC chooses to submit a claim for services non-covered by Medicaid, it MUST bill these services as non-covered charges. Failure to include these as non-covered charges will result in overpayments. It is each FQHC's responsibility to inform the State Fiscal Contractor of all overpayments. Recovery of all overpayments is a Medicaid requirement.

To expedite the processing of Medicare crossover claims, please use the codes that Medicare has instructed you to use for revenue codes 520-910

e) The coding systems acceptable by the Division are the ICD-9-CM (International Classification of Diseases - 9th Edition - Clinical Modification) for diagnosis(es), and the HCPCS (Health Care Administration Common Procedural Coding system) Level I (CPT) and Level II (HCPCS alpha numeric codes), the National Uniform Billing Committee's UB 04 revenue codes, and CDT (Current Dental Terminology) for procedures.

f) All dental services by FQHC/RHC dentists in all settings, including dental work performed in the outpatient and inpatient hospital setting with/without anesthesia should be submitted using codes D9999 (dental services for children/youth under 21 years of

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age), D0140 (with the ICD-9 diagnosis code 525.9, D0140 identifies adult emergency dental services), or D2999 (used for adult preventive and restorative services). Claims for dental services must be filed using the American Dental Association (ADA) form 2006.

21.4.5 Authorization

The following procedures address both the requirement that professional services performed by FQHCs and RHCs are claimed under the FQHC/RHC Medicaid provider number and that authorization requests comply with MQD rules.

The request for authorization of services on the 1144 form must have the requesting physician's name (printed or typed), the physician's signature, and date in the appropriate blocks. At the time of the request for service, the physician must be a contracted provider with the FQHC/RHC.

In the "Provider Number" block, enter the FQHC provider number.

In the "Contact Name" block, enter "FQHC" or "RHC" and the name of the FQHC/RHC AND the contact name (if different from the physician).

In the "Telephone Number" and "Fax Number" blocks, enter the FQHC telephone/fax numbers at which that the requesting physician can be contacted if additional information is needed to process the 1144 form.

It will be the responsibility of the FQHC or RHC to forward any and all Prior Authorization Correspondence Letters to the requesting physician.

21.4.6 Billing for Individuals who are Eligible for Medicare and Medicaid

When services are rendered to Medicaid clients 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.

Federally Qualified Health Centers**21.4.7 Appeals**

An FQHC or RHC may appeal a decision made by the Department and shall be afforded an opportunity for administrative hearing under HRS Chapter 91. An FQHC or RHC aggrieved by the final decision and order of such an administrative hearing shall be entitled to judicial review in accordance with HRS Chapter 91, or may submit the matter to binding arbitration pursuant to HRS Chapter 658A.