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MEMORANDUM

MEMO NOS.
ADM – 1011 (QUEST)
ADMX – 1014 (QExA)
ACS M10-09

TO: QUEST Health Plans
QExA Health Plans
FQHCs and RHCs

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

SUBJECT: GUIDANCE ON HEALTH PLAN REIMBURSEMENT TO FQHCs AND RHCs

This memo provides guidance to the QUEST and QUEST Expanded Access (QExA) health plans on payment of Prospective Payment System (PPS) reimbursement to both Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). This memo is developed in a question and answer format based upon frequently asked questions of the Med-QUEST Division. The contents of this memo are effective January 1, 2010.

**1. Who is an FQHC covered professional?**

To be eligible for PPS reimbursement, services must be delivered exclusively by the following licensed health care professionals that are a resident of the State of Hawaii: physician (Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Optometry, and Doctor of Podiatry), physician's assistant (PA), nurse practitioner (advanced practice registered nurse (APRN)), certified nurse midwife (APRN with subcategory), visiting nurse, clinical social worker, clinical psychologist, and licensed dietitians and within their scope of practices.

Within the legal authority of an FQHC or RHC to deliver, as defined in Sections 1905 (a)(2)(C) and 1905 (a)(2)(B) of the Social Security Act and Code of Federal Regulation, Part 405 as amended and the Hawaii State Plan:

a. Medical Visits provided by physician (Doctor of Medicine, Osteopathy, Optometry and Podiatry), physician's assistant (PA), nurse practitioner (APRN), certified nurse midwife (APRN with subcategory), or visiting nurse[1];

b. Behavioral Health Visits provided by a psychiatrist, psychologist, licensed social worker in behavioral health or APRN in behavioral health;

c. Dental Visits (for those under the age of 21) provided by a Doctor of Dentistry [Note: Dental services are carved out of the Medicaid managed care programs, are paid for by the Medicaid dental contractor, and have a separate PPS rate.];

d. Substance Abuse treatment provided by a psychiatrist, psychologist, or licensed social worker in behavioral health or APRN in behavioral health; and

e. EPSDT visits provided by a physician, physician's assistant (PA), or nurse practitioner (APRN).

**2. What services are eligible for PPS reimbursement?**

The following criteria for the service must be met for PPS reimbursement:

a. Actually provided by the FQHC or RHC, either directly or under arrangements;

b. Medicaid covered ambulatory service under the Medicaid program, as defined in the Hawaii Medicaid State Plan;

c. Provided to a Medicaid recipient;

d. Delivered exclusively by the following licensed health care professionals: physician (Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Optometry, and Doctor of Podiatry), physician's assistant, nurse practitioner (APRN), certified nurse midwife (APRN with subcategory), visiting nurse, clinical

[1]Visiting nurse is defined as a licensed registered nurse, licensed practical nurse, or licensed vocational nurse that is employed by or receives compensation for the services from a FQHC or RHC and is a resident of the State of Hawaii. Visiting nurse services can only be rendered to a full-benefit dual eligible individual and furnished in a skilled nursing facility, a nursing facility or other institution used as the patient's home.

social worker, clinical psychologist, and licensed dietitians and within their scope of practices;

e. Provided in an outpatient settings 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 patient's place of residence, which may be a skilled nursing facility, a nursing facility or other institution used as a patient's home by any FQHC covered professional;

f. Within the scope of services provided by the State under its fee-for-service Medicaid program and its QUEST or QExA program, on or after August 1994; and

g. Supplies and services (including laboratory and radiology) incidental to the FQHC covered services listed above are included in the all-inclusive PPS rate (e.g., services such as vaccine administration, vaccines, J-codes, IUD, bone density, mammography and interpreter services would be considered 'incidental to' and included in the PPS reimbursement.).

**3. What services are excluded from PPS reimbursement?**

The following services are health plan covered services but not included in the PPS rate:

a. Services provided by a physical therapist, occupational therapist, or speech-language therapist;

b. Hospital services, including vaginal or Cesarean delivery (Global billing of Obstetrical services is therefore not allowed.);

c. Medications provided by a pharmacy that is part of the FQHC; and

d. Medical nutrition therapy or diabetes self-management program provided by a licensed dietitian.

The FQHC can bill the health plan FFS for health plan covered services that are not eligible for PPS reimbursement.

**4. Is medication management for behavioral health clients (billed with HCPCS code 90862) considered a behavioral health or medical visit?**

Medication management would be considered a behavioral health visit eligible for PPS reimbursement if the criteria in #1 and #2 are met.

**5. What occurs if a Medicaid recipient is seen in the FQHC by a qualified (PPS reimbursable) professional as well as other qualified or unqualified (not PPS reimbursable) professionals?**

Multiple contacts with the same qualified health professional that take place on the same day and at a single location shall constitute a single encounter. The FQHC/RHC should ONLY bill for a second encounter in the following scenarios:

a. After the first medical encounter, the patient suffers illness or injury requiring additional diagnosis or treatment not related to the first medical encounter; or

b. The patient makes one or more covered encounters for dental or behavioral health. Medicaid shall pay for a maximum of one PPS visit per day for each of these services in addition to one medical visit.

Contacts with one or more health professionals for the same service specialty (either qualified or unqualified) on the same day and at the same practice site shall constitute a single encounter. For example, a qualified medical physician seeing a Medicaid recipient for a medical office visit as well as any additional same day services provided by an unqualified professional such as a physical therapist would constitute a single encounter.

**6. What happens if Medicaid is the secondary payor for a PPS eligible service? Should the health plan have to pay up to the PPS rate or does the health plan reimburse up to the FFS rate?**

If the health plan has a contract with the FQHC/RHC, then payments will be paid first by Medicare and the health plan should pay the difference up to the Medicaid PPS rate. If the health plan does not have a contract with the FQHC/RHC, then payments will be paid first by Medicare and the health plan should pay the difference up to the Medicare FFS rate; MQD will reconcile the provider payments to the PPS rate.

**7. How are emergency room visits in an emergency room (ER) established in an FQHC reimbursed by the health plan?**

Like Medicare, MQD does not recognize free standing ERs. All PPS eligible services provided by an FQHC, to include both provider and facility costs, for which an FQHC has included in their MQD approved scope of services have been incorporated into the PPS rate. Accordingly, for MQD purposes, an FQHC outpatient visit whether for routine or emergent treatment any time of day is considered an encounter to be reimbursed at the PPS rate by health plans with a contract with the FQHC/RHC and at the Medicaid FFS rate by health plans without a contract. Health plans with a contract should not pay a separate facility fee; health plans without a contract are not required to

pay a separate facility fee. For PPS eligible services provided by a non-participating FQHC, MQD will reconcile the payments to the PPS rate.

8. **Are members in either the QUEST-ACE or QUEST-Net program covered by PPS?**

   FQHCs are reimbursed PPS for FQHC covered services provided as part of the health plan covered benefits to members in both the QUEST-ACE and QUEST-Net programs.

9. **Are members in the Basic Health Hawaii (BHH) program covered by PPS?**

   FQHCs will not be reimbursed PPS for members in the BHH program or for services beyond those covered under these limited benefit programs. Covered services provided to BHH members will be paid FFS by the QUEST health plans.

10. **Are podiatry visits covered as part of the PPS rate?**

    Yes.

11. **How should health plans handle global maternity billed in 2009 when services covered under the global are rendered in 2010 to avoid paying FQHCs twice for the same service since in 2010 pre-natal and post-partum visits should be billed and paid separately?**

    FQHC/RHCs should not bill using global obstetric codes. See FQHC Guidance for Maternity Cases – PPS for further guidelines.

12. **How have osteopathic manipulation services (CPTS 98925-98929) been handled in the past? Do these services qualify as a PPS encounter if provided by an Osteopath without an office visit? Or are these manipulation services without an OV paid FFS as a physical therapy type service?**

    Osteopathic manipulation services would be covered as a PPS encounter if provided by an Osteopath as an office visit (in accordance with #1 and #2).

13. **How have vision services provided by an Ophthalmologist been handled in the past? Do these services (92002, 92004, 92012, and 92014) qualify as a PPS encounter?**

    These services billed under these codes qualify as PPS eligible services.

**14. What happens if an FQHC or RHC has a new change of scope of service and, therefore a new rate after the health plan's capitation payments have been calculated?**

The health plans should continue to reimburse at the approved PPS rate until MQD revises the health plans' capitation payments to include the new rate. MQD will adjust the FQHC/RHC total payments through its reconciliation process until the health plans capitation payments have been adjusted.

**15. What happens if an FQHC or RHC starts performing a new procedure or administering a new medication that was never included in their PPS rate?**

The FQHC or RHC should request a new change of scope of service from MQD. If the new change of scope of service is approved, then the FQHC or RHC's PPS rate would be adjusted accordingly and addressed as described in #14.

**16. Do the following Health & Behavior Assessment/Intervention codes qualify for PPS encounter (96150-96155)?**

In accordance with ACS M03-20, only FQHC/RHCs with grants to provide integrated behavioral health services can utilize these codes (96150, 96151, 96152, and 96154) for health and behavioral assessments/interventions. Codes 96153 (group) and 96155 (family without patient) do not qualify for PPS reimbursement.

**17. How has Medicaid FFS handled the identification of lab and radiology services that are considered part of a covered visit? Does MQD have a list of lab, radiology and medicine codes that would always be considered part of the office visit?**

Supplies and services (including laboratory and radiology) incidental to the FQHC covered services listed above are a part of the all-inclusive PPS rate. Therefore, lab and radiology services that are part of a covered visit should not be separately billed and should be included as a secondary line item with a primary billable encounter such as an office visit.

**18. Do ultrasound services (e.g., 76805, 76815, etc.) qualify for PPS if provided by a covered provider?**

Ultrasound supplies and services are incidental to the FQHC covered services listed above as part of the all-inclusive PPS rate. Therefore, ultrasound services that are part of a covered visit should not be separately billed and should be included as a secondary line item with a primary billable encounter such as an office visit.

**19. Section 10.1 e of the State Plan Amendment indicates that 'To be eligible for PPS reimbursement, services must be delivered exclusively by the following licensed health care providers....'.**

**Can you clarify what the scope of 'delivered exclusively by' means in reference to a covered provider? Would the Plan pay a case rate in a situation where a physician is supervising a non-covered staff and the physician is down the hall from the where the patient is being treated (99211 E&M is being billed)?**

Licensed healthcare professionals must be the ones to provide healthcare services in order to bill Medicaid at all (to include receipt of PPS reimbursement). One instance where supervision can be used is Physician Assistant (PA) services. Listed in #1a are the providers that are qualified to provide services.

Please direct any questions to Reuben Shimazu at 808-692-7983 or via e-mail at rshimazu@medicaid.dhs.state.hi.us.

# FQHC Guidance for Maternity Cases - PPS

Guidance for maternity cases in which services are provided in both 2009 and 2010 for the same pregnancy

During the calendar year 2009 PPS reconciliation process, the FQHC should inform MQD of the number of prenatal and postpartum services for proper reconciliation.

| Year Prenatal Services Rendered | Year Delivery / Termination Rendered | Year Postpartum Services Rendered (2 visits) | Billing to Health Plan | 2009 Reconciliation |
|---|---|---|---|---|
| 2009 | 2009 | 2009 | • Standard global billing to health plan with 2009 date of service. | • Provide MQD with prenatal and postpartum visit counts during reconciliation process |
| 2009 | 2009 | 2010 | • Standard global billing to health plan with 2009 date of service.<br>• Do not bill individual E&M visits for the two 2010 postpartum services included in global package.<br>• Bill individual E&M for any postpartum visits in excess of the 2 visits included in the 2009 global package. PPS reimbursement.<br><br>(Payment of global and PPS for 2010 postpartum visits would result in an overpayment by health plan) | • Provide MQD with prenatal and postpartum visit counts during reconciliation process. Include any postpartum visits covered under the 2009 global billing which were rendered in 2010. |

# FQHC Guidance for Maternity Cases - PPS

| Year Prenatal Services Rendered | Year Delivery / Termination Rendered | Year Postpartum Services Rendered (2 visits) | Billing to Health Plan | 2009 Reconciliation |
|---|---|---|---|---|
| 2009 | 2009 | 2009 & 2010 | • Standard global billing to health plan with 2009 date of service.<br>• Do not bill individual E&M visits even if postpartum visits covered under the global were rendered in 2010.<br>• Bill individual E&M for any postpartum visits in excess of the 2 visits include in global package. PPS reimbursement.<br><br>(Payment of the global and PPS for 2010 postpartum visits would result in an overpayment by health plan) | • Provide MQD with prenatal and postpartum visit counts during reconciliation process. Include any postpartum visits covered under the 2009 global billing which were rendered in 2010. |
| 2009 | 2010 | 2010 | • Do not bill the 2009 prenatal visits.<br>• Bill appropriate delivery-only code for fee-for-service reimbursement.<br>• Bill appropriate E&M for 2010 postpartum visits for PPS reimbursement. | • Provide MQD with 2009 prenatal visit counts during reconciliation process. |
| 2009 & 2010 | 2010 | 2010 | • Do not bill the 2009 prenatal visits<br>• Bill appropriate E&M for 2010 prenatal visits for PPS reimbursement.<br>• Bill appropriate delivery-only code for fee-for-service reimbursement.<br>• Bill appropriate E&M for 2010 postpartum visits for PPS reimbursement. | • Provide MQD with 2009 prenatal visit counts during reconciliation process. |