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October 28, 2010

MEMORANDUM

MEMO NOS.
ADM – 1011A (QUEST)
ADMX – 1014A (QExA)
ACS M10-09A
[Amendment to ADM-1011, ADMX-1014, ACSM10-09 Dated 07/20/10]

TO: QUEST Health Plans
QExA Health Plans
FQHCs and RHCs

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

SUBJECT: GUIDANCE ON HEALTH PLAN REIMBURSEMENT TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CENTERS (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, and within their scope of practice: 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.

2. What services are 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 and Code of Federal Regulation, Part 405, as amended;
- An FQHC covered ambulatory service 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 or QExA program, on or after August 1994;
- Provided to a recipient eligible for Medicaid benefits;
- Actually provided by the FQHC or RHC, either directly or under arrangements;
- Delivered exclusively by the licensed health care professionals in accordance with Item #1; and
- Provided in an outpatient setting during or after business 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, 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 and radiology) incidental to the FQHC covered services described above are included in the all-inclusive PPS rate (e.g., vaccine administration, vaccines, drugs (identified by HCPCS with alphas such as A, C, J, S, and Q), intrauterine devices, bone density, mammography, ultrasound, minor procedure trays and interpreter services).

3. What services are excluded from PPS reimbursement?

Services provided by other than a licensed FQHC covered provider as described in Item #1 are not eligible for PPS reimbursement. Other 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 provided 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 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 covered professional services provided to the eligible Medicaid beneficiary.

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

Medication management for behavioral health clients 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?

Contacts with one or more qualified health professionals or 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. For example, covered services provided by a Doctor of Podiatry or Doctor of Osteopathy qualify as a covered medical encounter, and 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. The FQHC/RHC should ONLY bill for a second PPS 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 qualified health professionals and one or more unqualified health professionals for the same service specialty on the same day and at the same practice site for covered services shall constitute a single PPS encounter for the service eligible for PPS reimbursement and one or more billable FFS claims for the PPS excluded services. 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 (PT) would constitute a single PPS encounter for the qualified physician's visit and separately billable FFS claim(s) for the PT services.

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 full Medicare FFS rate as the copayment; 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?

Services provided under a state-only funded medical assistance program are not eligible for PPS reimbursement. 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 in accordance with Items #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's or RHC's PPS rate would be adjusted accordingly and addressed as described in Item #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 Item #1 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.

    c: FO – Reuben Shimazu

    Attachments

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. • Do not bill individual E&M visits for the two 2010 postpartum services included in global package. • Bill individual E&M for any postpartum visits in excess of the 2 visits included in the 2009 global package. PPS reimbursement. (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. • Do not bill individual E&M visits even if postpartum visits covered under the global were rendered in 2010. • Bill individual E&M for any postpartum visits in <u>excess</u> of the 2 visits include in global package. PPS reimbursement. (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. • Bill appropriate delivery-only code for fee-for-service reimbursement. • 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. • Bill appropriate E&M for 2010 prenatal visits for PPS reimbursement. • Bill appropriate delivery-only code for fee-for-service reimbursement. • Bill appropriate E&M for 2010 postpartum visits for PPS reimbursement.	• Provide MQD with 2009 prenatal visit counts during reconciliation process.

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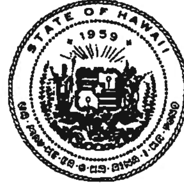

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In reply, please refer to:

In reply, please refer to:

Governor's Referral No.:

November 14, 2003

MEMORANDUM

ACS M03-20

TO: Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

FROM: Aileen Hiramatsu, Med-QUEST Division Administrator

SUBJECT: PROCEDURE CODES TO BE USED WHEN SUBMITTING CLAIMS AND CORRECTION OF CLAIMS PAID IN ERROR

To expedite the processing of claims submitted for services performed by FQHCs/RHCs, please review your claims submittal processes to assure they meet the following requirements:

- Claims must be submitted on UB92 or dental claim forms or electronically in UB92 or dental 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 UB92 claim form per Medicaid recipient.
- Only one claim per day can be submitted for dental services and for each allowable revenue code for a Medicaid covered service.

In its review of the reasons for delays in claims payment for FQHCs/RHCs, the Med-QUEST Division (MQD) discovered that many claims suspend for manual review. We know that by specifying the (Heath Care Financing Administration Common Procedural Coding System) HCPCS codes that FQHCs/RHCs should use and the circumstances pertinent to these codes, claims payment will be expedited.

CORRECTION OF CLAIMS PREVIOUSLY PAID INCORRECTLY

MQD and ACS will be recycling claims that were processed by HPMMIS with dates of service from November 1, 2002. We will reprocess both paid and denied claims. The reprocessing of these claims will result in the following:

- Non-Medicare claims will pay the PPS rate regardless of the billed charge amount
- Medicare claims will pay the difference between the PPS rate and the Medicare paid amount
- Claims billed on the CMS 1500 form will be denied
- Dental claims billed with D0120 that incorrectly denied for service limits will be paid
- Dental claims not billed with D0120 or D0140 will be denied
- Outpatient claims billed with 99199 or any codes other than 99232, 99212, 90801, 90806, 96150-96155, 92340 will pend to ACS. ACS will non-cover the charges for that service so that the provider will not be overpaid.

Claims affected by this reprocessin will appear on your remittance advice as an adjustment. The remittance advice will show the corrected amount to be paid, the original amount paid and the difference. We anticipate beginning the recycle of the claims during November 2003. We will notify you when it is completed.

For questions or clarification, please contact Ms. Angelina Payne at 692-8083.

Summary of Questions from QUEST memo ADM-1011

Behavioral Health

1. **#16: Can you provide us the names of all FQHCs who have grants and are eligible for the PPS case rate when codes 96150-96155 are billed?**

   At this time, no FQHCs have grants to bill for these codes. If an FQHC does have an active grant to bill these codes, please contact Janet Williams at the Med-QUEST Division at 692-8174 or jwilliams@medicaid.dhs.state.hi.us.

2. **Do group psychotherapy codes such as 90846, 90847, 90849, 90853 and 90857 qualify for PPS reimbursement?**
   The information below assumes a qualified PPS reimbursable health professional for a Medicaid covered service provides the services.

   90846 - Family psychotherapy (without the patient present): Not PPS, no face-to-face encounter with patient. In addition, this service is not eligible for Medicaid fee-for-service (FFS).
   90847 - Family psychotherapy (conjoint psychotherapy) (with patient present): PPS
   90849, 90853, 90857 - various types of group psychotherapy: Not PPS, PPS requires contact with a single patient at a time. In addition, this service is not eligible for Medicaid fee-for-service (FFS).

3. **We do not understand what grants the memo is referencing in question #16. We have been billing these HCPCS codes for years.**

   MQD issued a memo to the FQHC (ACS M03-20) in November 2003 (attached) describing how to bill MQD for FQHC provided services. The Health & Behavioral Assessment/ Intervention codes listed in question #16 were utilized under a medical revenue code, not under a behavioral health revenue code. These codes were only to be utilized by one FQHC that obtained a grant to perform specific interventions for their patients.

   If an FQHC wanted to use a code for a behavioral health PPS visit, they must utilize the behavioral health codes identified in the ACS M03-20 memo. MQD does not consider that an intervention less than 20 minutes justifies an additional behavioral health PPS visit.

4. **Is medication management for behavioral health patients (billed with HCPCS code 90862) reimbursable at the PPS rate when accomplished through a psychotherapy visit? In addition, does MQD similarly recognize such medication management visits as eligible for PPS reimbursement when provided remotely through a telemedicine consultation?**

   Per Memo question #4, medication management is an FQHC behavioral health visit if all other eligibility criteria are met. Per Memo question #5, Medicaid shall pay a maximum of one PPS visit per day for each of these (medical, behavioral and dental) services. If a psychotherapy visit is already billed for the day then an additional behavioral health medication management visit would not be billable.

   FQHC PPS reimbursable encounters must be delivered exclusively by a covered professional in an outpatient setting (face to face) thus telemedicine consultations would not be eligible for PPS reimbursement.

5. **Paragraph #16 of the July 20th Memo states that "Codes 96153 (group) and 96155 (family without patient) do not qualify for PPS reimbursement." Please confirm that the Plans are required to pay the FQHC for such service codes at the Medicaid fee-for-service level.**

   See answer to question #2.

6. **How will FQHCs with grants to provide integrated behavioral health service, which are authorized to use Health and Behavior Assessment/Intervention codes 96150, 96151, 96152 and 96154, be identified to the health plans?** (See July 20th Memo at ¶ 16.)

   If MQD is aware of any FQHCs that have grants to provide integrated behavioral health services, then MQD will share this list of FQHCs with the health plans. Also, see answers to questions #1 and #3.

Dental

7. **Why does the memo eliminate Dental Hygienists as a covered professional category?**

   Dental hygienists are not independent providers under Medicaid or under State law; they work under the direct or general supervision of licensed dentists. Services provided by dental hygienists are not eligible for PPS. If the dentist has seen the patient and indicates in writing in the dental record that cleaning or a fluoride application is needed and can be done by the hygienist, the hygienist can perform these services. If the hygienist provides a service on the same day as a dentist, the dental hygienist service is included in the dental visit, which is eligible for PPS reimbursement, and not separately reimbursable. If the hygienist performs the service on a different day than a dentist, the hygienist service can be billed at the FFS rate.

Incident To situations within PPS reimbursement

8. **#5: The example in the last paragraph indicates that physical therapy services provided on the same day as an office visit would be considered 'incident to' the visit and not paid separately. This seems to be in conflict with the physical therapy guidance provided in 3(a). Please clarify.**

   Question #5 of the FQHC memo was not answered correctly. MQD will amend the memo to remove the inconsistency between question #5 and #3a.

9. **# 5: This question and answer states contacts with one or more health professionals for the same services specialty (either qualified or unqualified) on the same day and at the same practice shall constitute a single encounter. In a situation where an APRN does an office visit and the same or different APRN does a medical nutrition or diabetes self-management visit on the same day, does that mean only a single encounter is eligible and we would pay the PPS case rate and deny the medical nutrition or diabetes self-management which we would normally pay FFS?**

   See revision to Memo question #5.

10. #5: Is the same true if a physician does an office visit and an APRN does a medical nutrition or diabetes self-management visit?

See revision to Memo question #5.

11. #5: Please define and provide an example of 'service specialties'.

We use the term 'same service specialty' to designate medical vs. behavioral vs. dental PPS codes. For example, if a member goes to the FQHC and sees three different qualified or unqualified professionals for a medically necessary medical purpose, then MQD counts this as one encounter for medical PPS reimbursement. If the member goes to the FQHC and sees a qualified professional for a medical purpose and a qualified professional for a behavioral health purpose, then the FQHC can bill this as two encounters: one medical and one behavioral health.

12. Are podiatrist visits for diabetic foot care reimbursable at the PPS rate as a second encounter if they take place on the same day as a medical visit?

No. See answer to question #11.

13. The physical therapy example provided in the last paragraph of Question #5 of the July 20th Memo appears to be in conflict with the physical therapy guidance provided in Question #3a. Please confirm that the response to Question #5 regarding multiple contacts in a single day is not intended to exclude the FQHC from billing for additional visits that are non-FQHC services and therefore not PPS reimbursable. For example, if a patient comes to an FQHC for a medical visit (by a MD, DO, or a Podiatrist), can a visit to a physical, speech or occupational health therapist be performed on the same day, either at the same location or at another location, that would be reimbursable separately? Note that by Medicare cost principles, non-FQHC services such as physical therapy are reported as "non-reimbursable costs" for purposes of determining an FQHC's cost rate, thus the costs of providing such non-FQHC services are not included in the FQHC's PPS rate. Accordingly, a separate reimbursement rate is warranted for such non-FQHC services. MQD's response in this Paragraph 5 appears to be in conflict with Section 10.8 of the approved SPA which supports separate payment for non-FQHC Services.

See revision to Memo question #5.

Licensed Dietitian and Diabetes Self-Management

14. #3(d): Are medical nutrition therapy & diabetes self-management services provided by a qualify provider eligible for PPS reimbursement?

Yes, medically necessary medical nutrition therapy and diabetes self-management (DSM) services are eligible for PPS when in accordance with Memo items #1 and #2, and they are considered medical encounters. For DSM to be considered within a FQHC qualified professional's scope of practice, that provider must be a certified diabetes educator. Question #3d of the FQHC memo was not answered correctly. MQD has amended the memo to remove the inconsistency regarding these services.

15. The memo is contradictory on PPS reimbursement for dietitians.

For dietitian services to be reimbursed the PPS rate, those dietitians must be licensed, must provide services within their scope of practice, and must be medically necessary PPS eligible services under the Hawaii Medicaid State Plan. Hawaii does not currently license dietitians.

16. Under what circumstances are dietitian services reimbursable?

See question #15 for further information.

17. Please clarify the circumstances wherein medical nutrition therapy and diabetes outpatient self-management services provided by a qualified health care professional (e.g., MD, DO or APRN) other than a licensed dietitian would be eligible for reimbursement at the PPS rate.

See question #14.

Obstetric Services

18. #11: Can we please get a copy of the FQHC guidance for Maternity Cases?

Attached is the FQHC guidance for Maternity Cases.

19. #18. What if the ultrasound services (76805, 76815, etc) are provided outside of the covered visit? Example: If a physician does an ultrasound between prenatal office visits, does the 76805 qualify for PPS case rate payment?

If a FQHC qualified professional performs an ultrasound as within that professional's scope of practice, then this service would be eligible for PPS reimbursement provided it is medically necessary and no other PPS eligible medical encounter occurred on the same day.

20. "The supplies and services incidental to FQHC" list is incredibly comprehensive and unworkable: an IUD for example costs way more than the PPS rate!

FQHC's PPS rate is a summary of all of the costs that are included in caring for all of the consumers that access medically necessary FQHC services. Some consumers receive services that cost more than the PPS rate and others less. The PPS rate is in effect an average. Therefore, even though an IUD costs more than the PPS rate, the cost for the IUD was absorbed in the development of the PPS rate.

All of the supplies that are listed have been included in the FQHC's PPS rate. If a specific FQHC believes that certain supplies were not included their PPS rate, the FQHC can compile documentation supporting this and submit to the MQD.

21. **When a licensed health care professional, whose services are otherwise eligible for PPS reimbursement, as described in Paragraph 1 of the July 20th Memo, provides both the technical and professional components of an ultrasound procedure furnished to an OB/GYN patient, is the encounter at which the service is provided reimbursable at the PPS rate?**

    MQD policy states that ultrasound supplies and services are incidental to the FQHC covered services such as an E&M encounter. If this additional service is provided on the same day as the E&M encounter, then the same day service rules would apply and only the E&M encounter would be reimbursed at the PPS rate. See also question #19 above.

Medicare

22. **Please clarify the definitions of and distinguish between a "Qualified Medicare Beneficiary Plus," ("QMB Plus"), and a "Full Benefit Dual Eligible," ("FBDE"), who are eligible for outpatient services at locations away from the FQHC facility site pursuant to SPA 08-007 Supplement 1 to Attachment 4.19-B.**

    Medicaid in Hawaii treats QMB Plus and FBDE's as the same. Both have access to full Medicaid benefits. MQD uses the term FBDE to refer to these categories.

23. **Please reconcile the provisions of SPA Supplement 1 to Attachment 4.19-B, which state that QMB Plus and FBDE are eligible for outpatient services at locations away from the FQHC site, with Subparagraph 10.7(a)(vi) of the SPA and Paragraph 2(e) of the July 20th Memo, which state that services may be provided at a patient's place of residence only for FBDEs.**

    Since MQD treats both QMB Plus and FBDE's the same, FQHCs can use the guidance of the SPA and July 20th memo in caring for patients who have both Medicare and Medicaid or are FBDE.

24. **Please confirm that the terms "States [sic] payment limit" and "State Plan limit," which are used in the SPA Supplement 1 to Attachment 4.19-B, refer to an FQHC's PPS rate, and that, in the cases of all dual eligibles, the Med-QUEST Division will reimburse an FQHC for any difference between the payment received from Medicare and the full PPS rate to which the FQHC is entitled.**

    SPA Supplement 1 to Attachment 4.19-B terms "States payment limit" and "State Plan limit" refer to an FQHC's PPS rate. Also, see memo question #6.

Non-PPS covered services

25. **#3(d): Would these types of services trigger a case rate payment if provided by a qualified provider?**

    No.

Surgery

26. How should a pre- op consultation with a surgeon within the global days period be handled for PPS reimbursement? (Currently, this type of service would be denied due to CCI editing because it would be included in the surgery reimbursement if paid fee-for-service) Since the surgery is performed at the CHC and is paid PPS, would this pre-op consultation be paid at the PPS rate?

There is no global payment to FQHCs for PPS eligible services. If the pre-op consultation was performed by a FQHC covered professional, then this service would be eligible for PPS reimbursement. If the consultation is provided by a non-FQHC covered professional, then payment would be unbundled FFS.

27. How should a post- op follow up visit with a surgeon within the global days period be handled for PPS reimbursement ? (Currently, this type of service would be denied due to CCI editing because it would be included in the surgery reimbursement if paid fee-for-service) Since the surgery is performed at the CHC and is paid PPS, would this post-op visit be paid at the PPS rate?

There is no global payment to FQHCs for PPS eligible services. If the post-op follow-up visit was performed by a FQHC covered professional, then this service would be eligible for PPS reimbursement. If the consultation is provided by a non-FQHC covered professional, then payment would be unbundled FFS.

28. How should a pre- op visit with the member's PCP to give approval for the patient to have the surgery be handled for PPS reimbursement?

A pre-op visit with the member's PCP, who is a FQHC covered professional, to give approval for surgery is eligible for PPS reimbursement.

29. Please confirm that pre-operative examinations and post-operative follow-up visits that are not part of a surgeon's global billings for the surgeon's hospital surgeries are reimbursable at the PPS rate. Also, that an FQHC may look to the surgeon for payment for such post-operative follow-up visits that are included in the surgeon's global billing payments.

If all other FQHC PPS eligibility requirements are met, then pre-operative and post-operative visits would be reimbursed the PPS rate. This Q&A relates to PPS reimbursement issues only and will not address financial arrangements between the FQHC and employed or contracted professionals. However, is the surgeon receives a bundled payment and shares a portion of that payment with a FQHC for pre or post procedure care, separate encounter billing by the FQHC for those services would be considered duplicate.

Vision

30. #2g: Is vision eyeware (e.g. frames and lenses) considered a supply that would be incidental to the covered vision and not paid separately?

Yes.

31. **#2g: Do eyeware fittings (92340-92358) codes trigger a PPS case rate payment if claim does not include an office visit code?**

    No.

32. **#2g: Do eyeware repair (92370-92371) codes trigger a PPS case rate payment if claim does not include an office visit code?**

    No.

33. **#13: Is an Ophthalmologist an eligible PPS provider type?**

    Yes.

34. **#13: When a PPS case rate is paid for vision, should services and supplies including glasses be considered incident to?**

    Yes.

<u>Other General Questions</u>

35. **Has the State adhered to Medicaid law in issuing this memo?**

    Yes. MQD has followed the CMS approved State Plan that governs FQHC reimbursement in drafting this memo.

36. **#12: Please provide additional guidance on this section. If an OMT service (98925-98929) is billed without an E&M code should the service be paid at the PPS case rate or does an E&M code need to be billed with the OMT code to qualify for PPS case rate payment?**

    Either would constitute a PPS eligible medical encounter of which only one can be claimed on the same day.

37. **#12: We were not sure how the phrase 'as an office visit' should be interpreted.**

    An office visit is a visit that uses an E&M code to bill.

38. **#12: Osteopathic manipulation is eligible for the PPS case rate when done by an Osteopath. Does this mean the physician specialty must be Osteopath and if not, the service is not eligible for the PPS case rate?**

    Yes. A service eligible for PPS must be provided by an FQHC covered professional and within their scope of practice.

39. If there is not a PPS visit within 10 days of the services listed in 2g, how is the health plan going to pay?

The FQHC can bill the health plan FFS if there is no PPS visit associated with the use of the supply or service (i.e., laboratory or radiology).

40. Why is the memo effective Jan 1, 2010 despite being dated July 20, 2010?

Med-QUEST Division (MQD) has reimbursed the health plans in their capitation payments to pay contracted FQHCs at the PPS rate since January 1, 2010 (for QUEST) and February 1, 2009 (for QExA). This memo is providing guidance to the health plans to assure that the FQHCs PPS rates are paid accurately. The health plans will reprocess any incorrectly paid claim back to January 1, 2010 (the effective date of guidance of this memo).

41. The memo excludes all hospital services (despite this being a defined covered service in the most recently published Medicaid manual online (now offline)).

A few sections of the Medicaid Provider manual were accidentally posted prior to being completely reviewed within the MQD. The chapters that were removed are being revised and will be reposted when accurate.

42. How should the FQHCs obtain reconciliation of claims that the QUEST and QExA health plans have incorrectly denied?

FQHCs should try to resolve their issues with the health plan first. If the FQHC is unable to resolve their issue with the health plan, they should contact the MQD to aid in resolution. Please contact Patti Bazin at either 692-8083 or pbazin@medicaid.dhs.state.hi.us.

43. Please confirm that G0101 ("Well Woman Exam") should be paid at the PPS rate.

FQHC's should not bill G0101 as a replacement code to an E&M code, but may use this code in conjunction with an E&M code that will be reimbursed at the PPS rate if provided by an FQHC qualified professional. The health plans should not reimburse code G0101 at the PPS rate if billed alone.

44. Please provide guidance as to whether payment of 99211 should be reimbursed at PPS case rate or fee-for service.

It is the expectation of MQD that 99211 billings are utilized to bill for the supervision of services. Services provided by non-covered professionals under the supervision of a covered professional do not meet the PPS eligibility criteria.

45. If 99211 is reimbursed a fee-for-service, how should other services provided during the visit, such as drugs billed under a J-code be reimbursed?

Fee-for-service.