

SECTION 2

Rural Health Clinics and Federally Qualified Health Centers Services

Table of Contents

1	GENERAL POLICY	2
1 – 1	Clients Enrolled in a Managed Care Plan	3
1 - 2	Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)	3
1 - 3	Billing.....	3
1 - 4	Definitions.....	4
1 - 5	Co-payment Requirement	6
2	COVERED SERVICES	7
3	LIMITATIONS	8
4	NON-COVERED SERVICES.....	8
5	BILLING CODE.....	9
6	PROSPECTIVE PAYMENT SYSTEM.....	9
	INDEX	11

1 GENERAL POLICY

Rural Health Clinics

Rural health clinics (RHCs) are clinics that are located in areas designated both by the Bureau of the Census as rural, and by the Secretary of the Department of Health and Human Services as medically underserved. RHCs are primarily ambulatory, outpatient office type services furnished by physicians and other approved providers. Trained primary care health professionals administer health care services to the community when access to traditional physician care is difficult or limited. RHCs have been eligible to participate in the Medicare program since 1978, and a clinic certified under Medicare will be deemed to meet the standards for certification under Utah Medicaid.

The clinic or center must be under the medical direction of a physician and have a health care staff that includes one or more physicians, and one or more nurse practitioners (NP) or physician assistants (PA). A physician, nurse practitioner, certified nurse midwife (CNM) or physician assistant must be available to furnish patient care services at all times the clinic or center operates. The staff may also include ancillary personnel who are supervised by the professional staff.

The RHC must directly furnish routine diagnostic and laboratory services, have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC, have available drugs and biologicals necessary for the treatment of emergencies, not be a rehabilitation agency of a facility that is primary for mental health treatment. The RHC must furnish certain laboratory tests (see laboratory services definition below).

RHCs may establish a sliding fee scale if it is uniformly applied to all patients.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are facilities that provide services, such as primary care, similar to those provided in RHCs, but also include preventive primary services. They are required to be community-centered, and either not-for-profit or public organizations that emphasize coordination of care. Like RHCs, they are facilities that are primarily engaged in providing outpatient services that are typically furnished in a physician's office. FQHCs must have a core staff of appropriately trained primary care clinicians and meet other clinical requirements, and if operated by a physician assistant, nurse practitioner or other health professional, must have a supervision arrangement with a physician. There are three types of organizations that are eligible to enroll in Medicare as an FQHC: health center grantees under Section 330 of the Public Health Service Act (i.e., migrant health centers, community health centers, public housing health centers); health center look-alikes (meets definition of health center under Section 330, but does not receive grant funding); and outpatient health programs operated by a tribe or tribal organization.

A FQHC must serve a designated medically underserved area or population, and offer a sliding fee scale to persons with incomes below 200% of the federal poverty level. FQHCs may be located in rural or urban areas.

Both RHCs and FQHCs are reimbursed with an all-inclusive payment rate that incorporates per visit payment limits and provider productivity caps. The RHCs and FQHCs must be in compliance with applicable federal, state and local laws for licensure, certification and registration.

The statutory requirements clinics must meet to qualify for Medicare benefits for RHCs and FQHCs are found in sections 1861(aa)(2) and (4), respectively, of the Social Security Act (the Act), and the regulations pertaining to these clinics are found at 42 C.F.R. 491 Subpart A and 42 C.F.R. 405.2400 Subpart X. (Medicaid follows Medicare definitions as defined in 42 U.S.C. 1395x(aa).)

1 – 1 Clients Enrolled in a Managed Care Plan

RHCs and FQHCs may provide services to Medicaid clients who are enrolled in a managed care plan, as well as to fee-for-service clients. Clinics must bill the appropriate payment source. A Medicaid client enrolled in a managed care plan (MCP) or Prepaid Mental Health Plan (PMHP), must receive all health care services through that plan. Refer to Section 1 of the Utah Medicaid Provider Manual, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, refer to Section 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning service coverage or payment from a managed care plan must be directed to the appropriate plan. Medicaid does *not* process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. However, it is also the provider's responsibility to verify the type of coverage held by the client. Because eligibility information as to which plan the client must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Billing

Services may be billed electronically or on paper, using the CMS-1500 (08/05) claim format. Medicaid encourages electronic billing. The billing code for RHCs and FQHCs is T1015. Mistakes can be corrected immediately, and claims are processed without delays. Electronic claims may be submitted until noon on Friday for processing that week. Refer to Section 1 of this manual, Chapter 11, for more information on billing claims.

1 - 4 Definitions

Definitions of terms used in other Medicaid programs are available in Section 1 of the Utah Medicaid Provider Manual. Definitions applicable to RHCs and FQHCs are provided below.

Ambulatory Services: Ambulatory services other than those specifically identified as RHC or FQHC services in the State Plan can be provided at the clinics. These services must be provided under the single rate per visit that is based on the cost of all services furnished by the clinic.

The Department: The Department is the Utah Department of Health.

Encounter and visit: Utah Medicaid generally follows the definitions of encounter, visit and health professionals as Medicare. These definitions specify what types of clinic activities constitute billable encounters. An RHC or FQHC visit is defined as a medically necessary, face-to-face (one-on-one) encounter between the patient and a health professional during which time services are provided which are reimbursable under the State Plan. For both types of clinics, the health professional includes a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist or clinical social worker. For FQHCs, the encounter also may include qualified providers of medical nutrition therapy (MNT) and diabetes self-management training (DSMT) services.

Multiple encounters in single day: Encounters with more than one health professional (and multiple encounters with the same health professional) which take place on the same day and at a single location constitute a single visit. This single-visit definition applies regardless of the length or complexity of the visit, or whether the second visit is a scheduled or unscheduled appointment. This would include situations where the patient has a medically necessary face-to-face visit by the health professional, and is then seen by another health professional, including a specialist, for further evaluation of the same or different condition on the same day. Exceptions include cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment; or the patient has a medical visit and also a separately billable health visit such as a dental or mental health visit.

Dental encounter: A dental encounter is an encounter between a patient and a dentist or dental hygienist/oral therapist under the supervision of a dentist. All dental hygienist or oral therapist services are included under the encounter definition.

Mental health encounter: A mental health encounter is an encounter between a patient and a licensed psychologist or licensed independent social worker for the provision of covered psychological services.

Medical visit: A medical visit is a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, or a visiting nurse; and for FQHCs only, a medical visit also includes a separately billable medical nutrition therapy visit or a diabetes outpatient self-management training visit.

Home-bound visit: A visit can also be between a home-bound patient and a registered nurse, licensed practical nurse or licensed vocational nurse under certain conditions. Telephone or electronic communication between a physician and a patient, or between a physician and someone on behalf of a patient, are considered physicians' services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Visit with services incident to medical services: Visits at which a patient receives services incident to medical services (e.g., laboratory or x-ray) do not qualify as separate, reimbursable visits.

Similarly, medical supplies used as part of the visit are considered part of the visit (e.g., bandages, dressings). Items provided to be used by the patient at home (e.g., contraceptive supplies, colostomy supplies) are to be billed and reimbursed according to the Medicaid medical supplies criteria. Drugs given as part of the visit are considered part of the visit, and drugs dispensed for at-home use are billed and reimbursed according to the Medicaid pharmacy criteria.

Vaccination or follow-up visits: Visits for the sole purpose of administering vaccinations (i.e., pneumococcal, influenza, hepatitis) or allergy shots, or similar follow-up visits that do not typically include evaluation and management by the health professional are generally not billable encounters. The patient is not responsible for a co-pay under these circumstances. (For reimbursement purposes, if the clinic uses the alternate payment system, the cost of the vaccines, serum, etc. are included in the annual cost report and separately reimbursed at cost settlement. If the clinic uses the Prospective Payment System, a visit for only a vaccination or allergy shot is not considered a billable encounter.)

Emergency services: RHCs and FQHCs provide outpatient services and are not typically set up for emergency care. However, both types of clinics must provide emergency medical emergency procedures as a first response to common life threatening injuries and acute illnesses, and have available the drugs and biologicals commonly used in life-saving procedures. RHCs are not subject to EMTALA regulations. After hours, FQHCs must provide telephone access to an individual who has the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer that patient to an appropriate provider or facility that is open.

Health professionals: health professionals are individuals who are currently licensed by the State of Utah to practice in their respective professions. These individuals include physician, osteopath, optometrist, podiatrist, certified nurse midwife, family or pediatric nurse practitioner, physician assistant, psychologist, licensed clinical social worker, dentist.

Home care recipient: a patient who is temporarily or permanently confined to his place of residence (not a nursing facility or hospital) because of a medical or health condition, including the need for special equipment or assistance, and the RHC or FQHC is located in an area that has a shortage of home health agencies. The limited status qualifies the patient for visiting nurse services provided by the clinic when the home is the most appropriate setting, and the services are furnished on a part-time or intermittent basis only. Services may be provided by a registered nurse, a licensed practical nurse, or a licensed vocational nurse under certain conditions.

Laboratory services: RHCs and FQHCs may provide laboratory services. Onsite laboratory services required by RHCs include chemical examination of urine, hemoglobin or hematocrit, blood sugar, examination of stool specimens for occult blood, pregnancy tests, and primary culturing for transmittal to a certified laboratory. FQHCs must provide additional laboratory services such as mammography, pap smear, prostate, colorectal, diabetes, glaucoma, and bone mass tests, and cardiovascular screening blood tests.

Physician: for purposes of RHCs and FQHCs, a physician includes several categories of health professionals: a doctor of medicine or osteopathy, and doctors of dental surgery, dental medicine, podiatry, optometry, and chiropractors. They must be licensed and practicing within the licensee's scope of practice and meet other requirements as specified. However, only a doctor of medicine or doctor of osteopathy are primary care physicians, and they are the only physicians allowed under Utah law to provide supervision of non-physicians. Dentists, podiatrists, optometrists and chiropractors are not considered primary care physicians. Thus, they do not meet the requirements to be either i) a physician medical director or ii) the physician or non-physician practitioner (NP, PA, or CNM) that must be available at all times the clinic is open. Still, a dentist, podiatrist, optometrist or chiropractor can provide

a medically necessary, face-to-face visit when the statutory and regulatory staffing requirements are otherwise met.

Preventive health services in FQHCs: FQHCs must provide preventive health services onsite or by arrangement with another provider, and include: preventive dental services, mental health and substance abuse services, transportation services necessary for adequate patient care, hospital and specialty care. Additional preventive services include prenatal and perinatal services, immunizations and vaccine-preventable diseases, pediatric eye, ear and dental screenings, voluntary family planning services. Generally, preventive health services are not within the scope of RHC benefits.

Supervision: RHCs and FQHCs which are not physician-directed must have an arrangement with a physician who is a doctor of medicine or osteopathy, that provides for the supervision and guidance of NPs, PAs and CNMs. When a consultation and referral plan is in place between the physician and non-physician in both respective offices, the acceptable standard for supervision in Utah is availability by telephone. Medical records must have sufficient documentation signed by a physician to reflect active participation of the physician in supervision and review of services provided by staff under supervision. In addition, the physician must be present for sufficient periods of time to provide the medical direction, services, consultation, supervision, and signing of medical records as specified in Utah Admin Code R156-12d-8(1). See Utah Admin Code R414-454.

1 - 5 Co-payment Requirement

Pursuant to Utah Admin Code R414-1-28, adult Medicaid clients will be required to make a co-payment for most services in a clinic. Both managed care and fee-for-service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-payment is required and for what type of services. The provider is responsible to collect the co-payment at the time of service or bill the client. "Encounter rates" will be prospectively adjusted to reflect these co-payments. Therefore, no message regarding co-payments will appear on the clinics' remittance statements.

For general information about the co-payment requirement, clients required to make a co-pay, exempt clients, and an example of the co-payment message on the Medicaid Identification Card, refer to General Information, Section 1 of this manual, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients.

A. Clients Exempt from Co-payments

If there is not a co-payment message under a client's name, the client does not have a co-payment. Also, do not require a co-payment for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

B. Services Exempt from Co-payments

Clients are not required to make a co-payment for the following types of services:

1. Family planning services.
2. Emergency services in a hospital emergency department.
3. Lab and X-ray services, including both technical and professional components.
4. Anesthesia services.
5. Administration of vaccinations or allergy shots (when no other medical services are provided).

C. Co-payment per Medical Visit

Except for exempt clients and exempt services described in items A and B above, Medicaid clients have a co-payment for services in a Rural Health Clinic.

2 COVERED SERVICES

Services provided at RHCs and FQHCs are primarily outpatient health care services, including routine diagnostic and laboratory services, and must be provided in accordance with applicable federal, state and local laws. Generally, clinic services are ambulatory, outpatient, primary care services provided by physicians, nurse practitioners, certified nurse midwives, or physician assistants. Services must be provided by a physician, or by another health professional under the supervision of a physician. FQHC services include all allowable RHC services. In addition, federal law specifically lists certain services as FQHC services, including, but not limited to: preventive primary services; tests such as mammography, pelvic, diabetes, glaucoma, prostate cancer, and colorectal cancer screening tests bone mass measurement; cardiovascular screening blood tests; and ultrasound screening for abdominal aortic aneurysm; diabetes outpatient self-management services; medical nutrition therapy services. (See Limitations and Non-Covered Services sections below for distinction between covered laboratory services and non-covered technical components of laboratory tests.)

Generally, clinic services include:

- A. Services and supplies furnished incident to the professional services of a physician, nurse practitioner, certified nurse midwife, physician assistant, or other licensed health professional in order to provide necessary medical care.

The service or supply should be:

1. Of the type commonly furnished in a physician's office and would be covered if furnished directly by the physician,
 2. Of a type rendered either without charge or included in the clinic bill,
 3. Furnished as an incidental, although integral, part of a physician's professional service,
 4. Furnished under the direct personal supervision of a physician or other professional staff by an employee of the clinic, (which may include non-physician service like health behavior assessment code 96150 through 96155).
 5. Drugs and biologicals furnished "incident to" the physician's professional services, are included within the scope of the program provided they cannot be self-administered by the recipient.
- B. Basic laboratory services essential for the immediate diagnosis and treatment of illness or injury. In order to qualify for reimbursement, laboratory services must be in compliance with the rules implementing CLIA and any amendments thereto.
 - C. Part-time or intermittent visiting nurse service and related medical supplies, other than drugs and biologicals, if the clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies. These visits are covered if a clinic registered nurse or licensed practical nurse provides services in the patient's place of residence in accordance with a treatment plan (reviewed every 60 days), and the services would not otherwise be available to that individual. (See also, definition of home care recipient, above.)

- D. Other ambulatory services which are otherwise provided in the State Plan. Services must meet all requirements of the State Plan and provider eligibility.
- E. Emergency medical care as a first response to common life-threatening injuries and acute illness. Drugs and biologicals commonly used in life saving procedures such as analgesics, anesthetics, (local), antibiotics, anticonvulsants, antidotes, and emetics, serums, and toxoids must be available.
- F. For FQHCs, diabetes self-management training (DSMT) is covered under CPT S9455 and must meet the criteria specified in the Utah Medicaid Provider Manual, Physician Manual. (DSMT is not a benefit of RHCs, but the provision of services by registered dieticians or nutrition professions might be considered incident to services in the RHC setting, provided all applicable conditions are met.) The criteria includes, but is not limited to: physician referral, a limit of 10 sessions per year, a period of at least 12 months since the patient has received training, and services must be provided by an American Diabetes Association (ADA) certified or Utah Department of Health certified instructor. Providers may contact the ADA (1-888-232-0822) or the Utah Department of Health, Chronic Diseases Diabetes Program (801-538-6141) for further information regarding instructor or provider certification. DSMT may be provided in either one-on-one face-to-face encounters, or in a class group setting. For FQHCs to qualify for a separate visit payment for DSMT services, the services must be a one-on-one face-to-face encounter. Group sessions do not constitute a billable visit; rather, the payment is a set fee based on an education program schedule (in 2013, \$25 per person per session).

3 LIMITATIONS

- 1. RHCs and FQHCs will only be reimbursed for one encounter per day per patient. Encounters with more than one health professional, and multiple encounters with the same health professional, which take place on the same day constitute a single visit. The provider may bill up to, but not exceeding, the established encounter rate.
- 2. An individual encounter rate is established for each clinic according to policy outlined in Chapter 6. The encounter rate will be a blended rate of all service costs, exclusive of costs or encounters for carve-out services. If a clinic itemizes multiple services provided to a single patient at a single location on the same day, payment will be made at the established encounter rate regardless of the total claim.
- 3. Medicaid implements editing programs such as the Correct Coding Initiative (CCI) to determine coverage. System edits can occur when a procedure is considered an integral component of another procedure, or when a diagnostic procedure is performed with a larger, more therapeutic procedure. Based on factors such as the payment date request or the complexity of the service, the editing program may determine that only a single procedure should be paid.

4 NON-COVERED SERVICES

- 1. Personal care services are not a benefit of the Medicaid program and are not covered under visiting nurse services for Rural Health Clinics.
- 2. Homemaker or chore services are not covered under the Medicaid program.

3. The technical component of laboratory services or use of diagnostic testing equipment is generally not covered. Some preventive services are encompassed in primary care, and these services may have a technical component such as laboratory service or use of diagnostic testing equipment. For FQHCs only, certain mandated preventive services include a laboratory test that is included in the FQHC visit. However, in general, if not part of the RHC or FQHC benefits, technical services (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims. All services in the RHC and FQHC benefits are reimbursed through the all-inclusive rate paid for each patient or encounter. Other non-covered services include ambulance services, prosthetic devices, and durable medical equipment.

5 BILLING CODE

The billing code for RHCs and FQHCs is HCPCS T1015.

6 PROSPECTIVE PAYMENT SYSTEM

There are two payment methodologies available to FQHCs in Utah, the prospective payment system (PPS) and an alternative payment method (APM), and FQHCs may elect to be paid under either methodology. RHCs are paid only under the prospective payment system. The PPS is a standardized rate that is the average of a particular clinic's reasonable costs for providing Medicaid services for the combined fiscal years 1999 and 2000, divided by the total number of visits by Medicaid patients to obtain an average per-visit cost rate. This average is the baseline per-visit rate to be applied in future years, adjusted by a cost-of-living index (Medicare Economic Index, or MEI). A Medicaid program may also adopt an alternative payment method so long as that rate results in payments that are no less than would have been received under the PPS. If an FQHC elects to change its payment method in subsequent years, it must elect to do so no later than thirty days prior to the beginning of the FQHC's fiscal year by written notice to the Department. The following provisions are contained in Utah Admin Code R414-9-1.

Prospective Payment System for FQHCs

The Department makes supplemental payments for the difference between the amounts paid by Managed Care Organizations (MCOs) that contract with FQHCs and the amounts the FQHCs are entitled to under the PPS as they are estimated and paid quarterly to the FQHCs. The Department makes quarterly interim payments no later than thirty days after the end of the quarter based on the most recent prior annual reconciliation. As necessary, the Department settles annual reconciliations with each FQHC.

The Department requires FQHCs to contract with local Mental Health service (MH) providers that are paid a capitation rate by DHCF to avoid duplicate payments. FQHC MH charges are billed to MH providers which reimburse FQHCs on the basis of the MH provider fee schedule.

For FQHCs servicing MCOs and capitated MH organizations, the Department annually determines and settles the difference between FQHC encounter rate and the MCO, MH, and third party liability reimbursement.

Alternative Payment Method for FQHCs

An FQHC is required to calculate the Ratio of Covered Beneficiary Charges to Total Charges Applied to Allowable Cost as part of its agreement with the federal government. As part of that calculation, it allocates allowable costs to Medicaid. The Department multiplies the Medicaid allowable costs by the

Medicaid charge percentage to determine the amount to pay. The Department makes interim payments on the basis of billed charges from the FQHC, which reduce the annual settlement amount. Third party liability collections by the FQHC for Medicaid patients also reduce the final cost settlements.

An FQHC participating in the APM must provide the Department annual cost reports and other cost information required by the Department necessary to calculate the annual settlement within ninety days from the close of its fiscal year, including its calculations of its anticipated settlement. The Department reviews submitted cost reports and provides a preliminary payment, if applicable, to FQHCs. Within six months after the end of the FQHC's fiscal year, the Department conducts a review or audit of submitted cost reports and makes a final settlement. This allows for inclusion of late filed claims and adjustments processed after the submitted cost report was prepared. If the Department overpaid an FQHC, the FQHC must repay the overpayment. If the Department underpaid an FQHC, the Department shall pay the FQHC the underpaid amount.

The Department compares the APM reimbursements with the reimbursements calculated using the PPS methodology described in R414-9-4 and pays the greater amount to the FQHC.

Prospective Payment System for RHCs

The Department reimburses all RHCs through a Prospective Payment System (PPS).

The Department pays each RHC the amount, on a per visit basis, equal to the amount paid in the previous RHC fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during that fiscal year.

For newly qualified RHCs after State fiscal year 2000, the Department establishes initial payments either by reference to payments to other RHCs in the same or adjacent areas with similar caseloads, or in the absence of other RHCs, by cost reporting methods. After the initial year, payment is set using the MEI used for other RHCs, and adjustments for increases or decreases in the scope of service furnished by the RHC during that fiscal year.

Sources for this manual:

Medicare Claims Processing Manual, Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers; and Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services.

Utah Admin Code R414-9.

42 C.F.R. § 405.2463.

42 U.S.C. § 1396a(bb), § 1396d(l)(1)-(2).

Social Security Act, Section 1861(aa)(2) (RHCs); Section 1861(aa)(4) (FQHCs).

INDEX

Billing.....	3	GENERAL POLICY	2
BILLING.....	9	Homemaker	9
BILLING CODE.....	9	LIMITATIONS.....	8
chore services.....	9	Managed Care Plan.....	3
Co-payment Requirement	6	NON-COVERED SERVICES.....	8
COVERED SERVICES.....	7	Personal care services	9
Definitions.....	4	PROSPECTIVE PAYMENT SYSTEM	9
Fee-for-Service Clients	3	Visit	7