

Section 2
Rural Health Clinics and
Federally Qualified Health Centers
Services

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1 General Information

This manual is designed for use with *Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information)* available at <https://medicaid.utah.gov/utah-medicaid-official-publications>.

1-1 General Policy

This manual provides coverage information for Medicaid members receiving medical care in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).

Rural health clinics (RHC) are located in areas designated as medically underserved. They primarily offer ambulatory, outpatient office type services furnished by physicians and other approved providers.

Federally Qualified Health Centers (FQHCs) are facilities whose main purpose is to enhance the provision of primary care services in underserved urban and rural communities. They are facilities primarily engaged in providing outpatient services typically furnished in a physician's office. Their services are similar to those provided in RHCs, but also include preventive primary services.

1-2 Fee-for Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid members. Medicaid members enrolled in a Managed Care Organization (MCO) (health, behavioral health, or dental plan) must receive services through that plan with some exceptions called "carve-out services," which may be billed directly to Medicaid. Medicaid members enrolled in MCOs are entitled to the same Medicaid benefits as fee-for-service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual.

Refer to the provider manual *Section I: General Information* for further information regarding MCOs.

Medicaid does not prior authorize service for an MCO

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCO when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCO will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment with a managed care organization. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. *Therefore, if a Medicaid member is enrolled in an MCO, a fee-for-service claim will not be paid unless the claim is for a "carve-out service".*

Eligibility tools

Eligibility and plan enrollment information for each member is available to providers from these sources:

- The Eligibility Lookup Tool: <https://medicaid.utah.gov/eligibility>

- AccessNow: 1 (800) 662-9651
- Member Services hotline at 1 (844) 238-3091

1-3 Definitions

Definitions of terms used in other Medicaid programs are available in *Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information)*. Definitions specific to the content of this manual are provided below.

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

Encounter and visit: Utah Medicaid generally follows the same 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.

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.

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 alternative payment method (APM), 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.)

Health professionals: Health professionals are individuals who are currently licensed by the State of Utah to practice in their respective professions.

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.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the state. 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 a physician medical director or the physician or non-physician practitioner (NP, PA, or CNM) that must be available at all times the clinic is open.

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.

Telehealth or Telemedicine Home Health Services: Telehealth or Telemedicine is an optional program. For information, refer to Section I: General Information and the Home Health Services Utah Medicaid Provider Manuals at the Utah Medicaid website at: <https://medicaid.utah.gov>.

2 Provider Participation Requirements

2-1 Provider Enrollment

Refer to provider manual, *Section I: General Information* for provider enrollment information.

3 Member Eligibility

A Medicaid member is required to present the Medicaid Member Card before each service, and every provider must verify each member's eligibility each time and before services are rendered. For more information regarding verifying eligibility refer to provider manual, *Section I: General Information, Verifying Medicaid Eligibility, Eligibility Lookup Tool*(<https://medicaid.utah.gov/eligibility>, or *AccessNow, 1(800) 662-9651*.

4 Program Coverage

4-1 Covered Services

Services provided at FQHCs and RHCs are primarily outpatient health care services, including routine diagnostic and laboratory 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. Services must be provided in accordance with applicable federal, state and local laws. 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 Chapter 5, Non-Covered Services and Limitations 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 to provide necessary medical care.

The service or supply should be:

- Of the type commonly furnished in a physician's office and would be covered if furnished directly by the practitioner,
 - Of a type rendered either without charge or included in the clinic bill,
 - Furnished as an incidental, although integral, part of a physician's professional service,
 - 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).
 - Drugs and biologicals furnished incident to the practitioner'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. 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 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.) Additional information may be found in the *Utah Medicaid Provider Manual, Home Health Services*.
- D. Other ambulatory services which are otherwise provided in the State Plan Amendment. Services must meet all requirements of the State Plan and provider eligibility.
- E. Clinics may provide emergency medical care as a first response to common life-threatening injuries and acute illness. RHCs and FQHCs provide outpatient services and are not typically set up for emergency care. However, both types of clinics must provide emergency medical procedures as a first response to common life threatening injuries and acute illnesses, and have available drugs and biologicals commonly used in life-saving procedures. RHCs and FQHCs are not subject to Emergency Medical Treatment & Labor Act (EMTALA) regulations. After hours, FQHCs must provide telephone access to an individual with 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.
- F. Diabetes self-management training (DSMT).
- FQHCs – Offer DSMT services as a benefit. To qualify for reimbursement a face-to-face encounter is required and must be provided as part of an encounter; it cannot be billed separately.
- RHCs - Do not offer DSMT services as a benefit, 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.
- G. FQHCs must provide preventive health services onsite or by arrangement with another provider, and include: well-child services, pediatric eye, ear, and dental screening, mental health and substance use

referrals, services that enable individuals to use the services of the health center (including outreach and transportation services. Additional preventive services include prenatal and perinatal services, voluntary family planning services, and immunizations against vaccine-preventable diseases.

- H. RHCs must directly furnish routine diagnostic and laboratory services, furnish various laboratory tests on site, and have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC. Generally, preventive health services are not within the scope of RHC benefits.

5 Non-Covered Services and Limitations

5-1 Non-covered Services

- Personal care services are not a benefit of the Medicaid program and are not covered under visiting nurse services for RHCs or FQHCs.
- Homemaker or chore services are not covered under the Medicaid program.
- 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, the technical component of certain mandated preventive services are not covered, this includes a laboratory test that is included in the FQHC visit.
- 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.
- For FQHCs, non-covered services include: preventive primary services such as group or mass information programs, health education classes, or group education activities; eyeglasses, hearing aids, and preventive dental services; also, ambulance services, prosthetic devices, and durable medical equipment.

5-2 Limitations

- RHCs and FQHCs are 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.
- 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.

- 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.

6 Billing

Billing code

The billing encounter code for RHCs and FQHCs is HCPCS T1015. In addition to the encounter rate, each procedure code must be listed on separate line.

Mobile Units

In accordance with Medicare requirement each permanent FQHC requires a separate agreement. Mobile units of an FQHC approved site are not required to enroll or bill separately, but must comply with Medicare health and safety standards.

Co-payment Requirement and Exemptions

Adult Medicaid members may be required to make a co-payment for services in a clinic. Both managed care and fee-for-service members can have a co-pay. The provider is responsible to collect the co-payment at the time of service or bill the member. “Encounter rates” are prospectively adjusted to reflect these co-payments. Except for exempt members and exempt services described below, Medicaid members have a co-payment for services in a Rural Health Clinic.

Prior to rendering service the provider should verify member eligibility and co-pay status using the Eligibility Lookup Tool at <https://medicaid.utah.gov/eligibility>, or AccessNow, 1-800-662-9651. Also refer to the Medicaid website <https://medicaid.utah.gov/medicaid-online>. Further information is found in Section 1: General Information.

Members who are always exempt from co-pay:

- Pregnant women. Add pregnancy diagnosis Z33.1 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.
- Individuals enrolled in Traditional Medicaid and are ages birth through twenty.
- American Indian and Alaska Native (AI/AN) individuals.

Services Exempt from Co-payments

Members are not required to make a co-payment for the following types of services (this list is not all inclusive):

- Family planning services. Emergency services in a hospital emergency department; however, non-emergency use of the emergency room department may result in a co-payment charge.
- Lab and X-ray services, including both technical and professional components.

- Anesthesia services.

6-1 Prior Authorization

Prior authorization (PA) information is provided on the Medicaid website, Coverage and Reimbursement Lookup Tool, <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

Prior authorization may be required for certain services; if so, a failure to obtain prior authorization may result in a payment denial by Medicaid. Providers must verify whether PA is necessary, and comply with applicable requirements.

6-2 Reimbursement

There are two payment methodologies available, the prospective payment system (PPS) and the alternative payment method (APM). The FQHCs may elect to be paid under either methodology. RHCs are paid only under the prospective payment system.

Prospective Payment System

The Department pays each clinic the amount, on a per visit basis, 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 clinic during that fiscal year. Thus, the PPS is a standardized rate that is the average of a particular clinic's reasonable costs for providing Medicaid services divided by the total number of visits by Medicaid patients to obtain an average per visit cost rate.

The Department makes supplemental payments for the difference between the amounts paid by Managed Care Organizations (MCOs) that contract with clinics and the amounts the clinics are entitled to under the PPS as they are estimated and paid quarterly to the them. 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 clinic.

The Department requires clinics to contract with local Mental Health service (MH) providers that are paid a capitation rate by Division of Medicaid and Health Financing (DMHF) to avoid duplicate payments. Mental health charges are billed to mental health providers which reimburse clinics on the basis of the mental health provider fee schedule.

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

Alternative Payment Method for FQHCs

FQHCs 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.

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 settlement.

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 twelve 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 and pays the greater amount to the FQHC.

7 **References**

- R414-45 Personal Supervision by a Physician.
- Social Security Act, Title 19, Section 1905 (l)(1) and (2)(A)
- United States Code 42 § 254b. Health Centers [42 USC 254b]

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