Washington State Health Care Authority

Medicaid Provider Guide

Federally Qualified Health Centers (FQHC)

[Refer to Chapter 182-548 WAC]

January 1, 2013

Washington State Health Care Authority

A Billing Instruction

About this Guide

This guide supersedes all previous *Federally Qualified Health Centers Medicaid Provider Guides* (billing instructions) published by the Health Care Authority (Agency).

What Has Changed?

Reason for Change	Effective Date	Page No.	Subject	Change
January code update (PN 12-109)	Jan.1, 2013	10	Determining whether a service is an encounter	Correcting the list under #7(c)(xi) to add code S9436 as an exception to the policy that S codes are excluded from encounter payments (that is, S9436 is eligible for encounter payments).

Copyright Disclosure

Fee Schedules

You may access the agency's Fee Schedules.

How Can I Get Agency Provider Documents?

To download and print Agency Provider Notices and Medicaid Provider Guides, go to the agency's Provider Publications website.

Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

Important Contacts

Note: This section contains important contact information relevant to Federally Qualified Health Centers (FQHCs). For more contact information, see the agency's *Resources Available* web page

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's *Resources Available* web page
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Who do I contact if I have questions regarding enrolling as a medical assistance-certified FQHC, overall management of the program, or specific payment rates?	FQHC Program Manager Office of Rates Development PO Box 45510 Olympia, WA 98504-5510 **Or Email:** FQHCRHC@hca.wa.gov

Definitions & Abbreviations

[Refer to WAC 182-548-1100]

This section defines terms and abbreviations, including acronyms, used in this Medicaid provider guide. Please refer to the agency's online Medical Assistance Glossary for a more complete list of definitions.

APM Index - The alternative payment methodology (APM) is used to update APM encounter payment rates on an annual basis. The APM index is a measure of input price changes experienced by Washington's federally qualified health center (FQHC) and rural health clinic (RHC) providers. The index is derived from the federal Medicare Economic Index (MEI) and Washington-specific variable measures.

Base Year – The year that is used as the benchmark in measuring a center's total reasonable costs for establishing base encounter rates.

Cost Report – A statement of costs and provider utilization that occurred during the time period covered by the cost report. FQHCs must complete a cost report when there is a change in scope, rebasing of the encounter rate, or when the agency sets a base rate.

Encounter - A face-to-face visit between a client and a qualified FQHC provider (e.g., a physician, physician assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

Encounter-Level Practitioner - The services of the following practitioners are billable as encounters if the services meet the criteria listed in these billing instructions. Encounter-level practitioners include, but are not limited to the following:

- Physicians and dentists;
- Dental Hygienist;
- Physician's assistants (PA) and advanced registered nurse practitioners (ARNP);
- Psychologists or clinical social workers;
- Visiting nurses, as described in federal regulation 42 CFR §405.2416;
- Licensed Independent Clinical Social Workers or Advanced Social Workers;
- Licensed Marriage and Family Therapists;
- Licensed Mental Health Counselors;
- Community Health Nurse (CHN);
- Registered Dietician (RD);
- Behavioral Health Specialist (BHS);
- Community Health Worker (CHW) acting under direction of a professional on the interdisciplinary team;
- Outpatient Chemical Dependency Treatment Centers;
- Medical provider/Qualified Chemical Dependency Counselor (QCDC); and
- Psychiatric ARNP.

Encounter Rate – A cost-based, facility-specific rate for covered FQHC services, paid to an FQHC for each valid encounter it bills.

Enhancements (also called managed care enhancements) -A monthly amount paid by the agency to FQHCs for each client enrolled with a managed care organization (MCO). MCOs may contract with FQHCs to provide services under managed care programs. FQHCs receive enhancements from the agency in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

Federally Qualified Health Center (FQHC) - An entity that has entered into an agreement with the Centers for Medicare and Medicaid Services (CMS) to meet Medicare program requirements under 42 CFR 405.2434 and:

- Is receiving a grant under section 329, 330, or 340 of the Public Health Service (PHS) act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 330 of the Public Health Service act;
- Based on the recommendation of the PHS, is determined by CMS to meet the requirements for receiving such a grant;
- Was treated by CMS, for purposes of part B, as a comprehensive Federally Funded Health Center (FFHC) as of January 1, 1990; or
- Is an outpatient health program or facility operated by a tribe or tribal organizations under the Indian Self-Determination Act or by an Urban Indian organization receiving funding under Title V of the Indian Health Care Improvement Act. (For the purposes of this publication, "center" and "FQHC" are synonymous.)

Fee-for-Service - A payment method the agency uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under the agency 's prepaid managed care organizations or those services that qualify for an encounter rate.

Interim Rate – The rate established by the agency to pay an FQHC for covered FQHC services prior to the establishment of a permanent rate for that facility.

Medical Assistance – The various healthcare programs administered by the agency that provide federal and/or state-funded healthcare benefits to eligible clients.

Medicaid Certification Date – The date that an FQHC can begin providing services to Medicaid clients.

Rebasing - The process of recalculating encounter rates using actual cost report data.

United States Department of Health & Human Services (DHHS) - The agency responsible for federal certification of FQHCs.

Federally Qualified Health Centers

What Is a Federally Qualified Health Center?

A federally qualified health center (FQHC) is a facility that is:

- Receiving grants under Title 42, Chapter 6A, Subchapter II, Part D, subpart i, section 254b of the U.S. Code (formerly known as Section 330 of the Public Health Services Act);
- Receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary, to meet the requirements for receiving such a grant; or
- A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self-Determination Act (PL93-638).

An FQHC is unique only in the methodology by which it is paid for services eligible for an encounter payment, not by the scope of coverage for which it is paid.

> **Note:** A corporation with multiple sites may be designated as a single FQHC, or each site may be designated as an individual FQHC, depending on the designation by the U.S. Department of Health & Human Services (DHHS).

Participation in the Medicaid FQHC program is voluntary.

- The agency allows only DHHS-designated FQHCs to participate in the agency's FQHC program.
- **Participating FQHCs** receive an encounter payment that includes medical services, supplies, and the overall coordination of the services provided to the agency client.
- **Nonparticipating DHHS-designated FQHCs** receive reimbursement on a fee-for-service basis.

What Is the Purpose of the agency's FQHC Program?

FQHCs are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities.

Basic Requirements for Services Provided in an FQHC

- FQHCs must furnish all services according to applicable federal, state, and local laws.

- Unless otherwise specified, FQHC services provided are subject to the limitations and coverage requirements detailed in the current Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide and other applicable billing instructions. The agency does not extend additional coverage to clients in an FQHC beyond what is covered in other Agency programs and State law.

- The FQHC must be primarily engaged in providing outpatient health services. Center staff must furnish those diagnostic and therapeutic services and supplies commonly furnished in a physician's office or the entry point into the health care delivery system. These include:

  - ✓ Medical history;
  - ✓ Physical examination;
  - ✓ Assessment of health status; and
  - ✓ Treatment for a variety of medical conditions.

- The FQHC must provide medical emergency procedures as a first response to common life-threatening injuries and acute illness. The FQHC must have available commonly used drugs and biologicals such as:

  - ✓ Analgesics;
  - ✓ Anesthetics (local);
  - ✓ Antibiotics;
  - ✓ Anticonvulsants;
  - ✓ Antidotes and emetics; and
  - ✓ Serums and toxoids.

Who May Provide Services in an FQHC?

[WAC 182-548-1300 (3)]

FQHC services may be provided by any of the following individuals in accordance with 42 CFR 405.2446:

- Physicians.
- Physician assistants (PA).
- Nurse practitioners (NP).
- Nurse midwives or other specialized nurse practitioners.
- Certified nurse midwives.
- Registered nurses or licensed practical nurses.
- Psychologists or clinical social workers.

What Are the Staffing Requirements of an FQHC?

[Refer to 42 CFR §491.7-8]

All of the following are staffing requirements of an FQHC:

- An FQHC must be under the medical direction of a physician.
- An FQHC must have a health care staff that includes one or more physicians.
- A physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), midwife, clinical social worker, or clinical psychologist must be available to furnish patient care services within their scope of practice at all times the center operates.
- The staff must be sufficient to provide the services essential to the operation of the center.

A physician, PA, ARNP, midwife, clinical social worker, or clinical psychologist member of the staff may be the owner or employee of the center, or may furnish services within their scope of practice under contract to the center. The staff may also include ancillary personnel who are supervised by the professional staff.

How Does the FQHC Enroll as a Provider?

[WAC 182-182-1200 (2)]

To enroll as a medical assistance provider and receive payment for services, an FQHC must do all of the following:

- Receive FQHC certification for participation in the Title XVIII (Medicare) program according to 42 CFR 491. Go to http://www.cms.hhs.gov/home/medicare.asp for information on Medicare provider enrollment.

- Sign a Core Provider Agreement (CPA). To obtain medical assistance certification as an FQHC, the center must contact the FQHC Program Manager directly to obtain the paperwork necessary to enroll with the agency (see Important Contacts).

- Operate in accordance with applicable federal, state, and local laws.

> **Note:** A center ***must*** receive federal designation as a Medicare-certified FQHC before the agency can enroll the center as a medical assistance-certified FQHC. Go to http://www.cms.hhs.gov/home/medicare.asp for information on Medicare provider enrollment.

When adding a new site or service, indicate on the CPA that you are an FQHC.

What Is the Effective Date of the Medicaid FQHC Certification?

[WAC 182-548-1200 (2)]

The agency uses one of two timeliness standards for determining the effective date of a Medicaid-certified FQHC:

- **Medicare's Effective Date:** The agency uses Medicare's effective date if the FQHC returns a properly completed CPA and FQHC enrollment packet ***within sixty (60) calendar days*** from the date of Medicare's letter notifying the center of the Medicare certification.

-OR-

- **Date the agency Receives the Core Provider Agreement:** The agency uses the date the signed CPA is received if the FQHC returns the properly completed CPA and FQHC enrollment packet ***sixty-one (61) or more calendar days*** after the date of Medicare's letter notifying the center of the Medicare certification.

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are Clients Eligible When Enrolled in an Agency's Managed Care Plan?

[Refer to WAC 182-538-060 and 095 or WAC 182-538-063 for GAU clients]

YES. When verifying eligibility using ProviderOne, if the client is enrolled in an Agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services[1] must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

Are Clients Eligible When Enrolled in Primary Care Case Management (PCCM)?

If a client has chosen to obtain care with a PCCM provider, eligibility information will be displayed on the Client Benefit Inquiry screen in ProviderOne. PCCM clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see the agency's *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

[1] Services excluded from this requirement include Maternity Support Services/Infant Case Management, Dental, and Chemical Dependency. These services are covered fee-for-service and do not require PCP approval.

Encounters

What Is an Encounter?

An encounter is a face-to-face visit between a client and an FQHC provider of healthcare services who exercises independent judgment when providing healthcare services to the individual client. For a healthcare service to be defined as an encounter, it must meet specific encounter criteria as described below. All services must be documented in the client's file in order to qualify for an encounter. Encounters are limited to one per client, per day except in the following circumstances:

- The client needs to be seen on the same day by different practitioners with different specialties; **or**
- The client needs to be seen multiple times on the same day due to unrelated diagnoses.

What Services Are Considered an Encounter?

[Refer to WAC 182-548-1300 (1)]

Only certain services provided in the center are considered an encounter. The FQHC must bill the agency for these services using HCPCS code T1015 and the appropriate HCPCS or CPT code for the service provided.

The following outpatient services qualify for FQHC reimbursement:

- Physician services specified in 42 CFR 405.2412.
- Nurse practitioner or physician assistant services specified in 42 CFR 405.2414.
- Clinical psychologist and clinical social worker services specified in 42 CFR 405.2450.
- Visiting nurse services specified in 42 CFR 405.2416.
- Nurse-midwife services specified in 42 CFR 405.2401.
- Preventive primary services specified in 42 CFR 405.2448.

Services and Supplies Incidental to Professional Services

Services and supplies incidental to the professional services of encounter-level practitioners are included in the encounter rate paid for the professional services when the services and supplies are:

- Furnished as an incidental, although integral, part of the practitioner's professional services (e.g. professional component of a x-ray or lab);
- Of a type commonly furnished either without charge or included in the FQHC bill;
- Of a type commonly furnished in a provider's office (e.g., tongue depressors, bandages, etc.);
- Provided by center employees under the direct, personal supervision of encounter-level practitioners; and
- Furnished by a member of the center's staff who is an employee of the center (e.g., nurse, therapist, technician, or other aide).

Incidental services and supplies as described above that are included on the center's cost report are factored into the encounter rate and will not be paid separately.

Determining Whether a Service Is an Encounter

To determine whether a contact with a client meets the encounter definition, all the following guidelines apply:

1. **Services Requiring the Skill and Ability of an Encounter-Level Practitioner**: The service being performed must require the skill and ability of an encounter-level practitioner in order to qualify as an encounter. A service does not qualify as an encounter simply because it is performed by one of these practitioners if the service is one that is normally performed by other health care staff.

   For example, if a physician performs a blood draw only or a vaccine administration only, these services are not encounters since they are normally performed by RNs. These services must be billed as fee-for-service (FFS) using the appropriate coding.

2. **Assisting:** The provider must make an independent judgment. The provider must act independently and ***not assist*** another provider.

Examples:	
Encounter:	A mid-level practitioner sees a client to monitor physiologic signs, to provide medication renewal, etc., and uses standing orders or protocols.
Not an Encounter:	A mid-level practitioner assists a physician during a physical examination by taking vital signs, history, or drawing a blood sample.

3. **Concurrent Care:** Concurrent care exists when services are rendered by more than one practitioner during a period of time. (Consultations do not constitute concurrent care.) The reasonable and necessary services of each practitioner rendering concurrent care are covered if each practitioner is required to play an active role in the patient's treatment.

For example, concurrent care may occur because of the existence of more than one medical condition requiring distinct specialized medical services.

4. **Each *individual* provider is limited to one type of encounter per day for each client, regardless of the services provided except in the following circumstances:**

   a. The client needs to be seen by different practitioners with different specialties; **or**
   b. The client needs to be seen multiple times due to unrelated diagnoses.

5. Encounter Locations - An encounter may take place in the health center or at any other location (such as mobile vans, hospitals, clients' homes, and extended care facilities) in which project-supported activities are carried out.

Services at the Center
Services performed at the center (excluding those listed in #7c on the next page) are encounters and are payable only to the center.

Services Away From the Center
A service that is considered an encounter when performed **in** the center is considered an encounter when performed **outside** the center (e.g., in a nursing facility or in the client's home) and is payable to the center.

A service not considered an encounter when performed **inside** the center is also not considered an encounter when performed **outside** the center, regardless of the place of service.

6. **Serving Multiple Clients Simultaneously** - When an individual provider renders services to several clients simultaneously, the provider can count an encounter for each client if the provision of services is documented in ***each client's*** health record. This policy also applies to family therapy and family counseling sessions. **Bill services for each client on separate claim forms.**

> **Note:** Professional services that are not normally provided to Medicare beneficiaries are not included on the center's Medicare cost report and are not used for the calculation of the center's encounter rate. Therefore, they have been excluded from the agency's list of services eligible for an encounter payment. Also, as described in Services and Supplies Incidental to Professional Services, many supplies used in a provider's office are considered incidental to the professional service and are bundled within the encounter rate.

> **Note:** Simply making a notation of a pre-existing condition or writing a refill prescription for the condition **is not significant enough** to warrant billing an additional encounter for the office visit.

7. **The agency determines a service to be an encounter if the following conditions are true:**

   a. The claim is billed on a CMS-1500 Claim Form for physician claims or a 2006 ADA Claim Form (effective July 1, 2008) for dental claims.

   b. One line-item procedure code equals T1015 (or T1015 with the HE modifier for mental health encounters).

   c. Another line-item with the code of the underlying service is billed with an amount greater than zero and a date of service matching that on the T1015 line (with the exception of mental health encounters, which are billed with the T1015-HE line only). The code of the underlying service must **not** be one of the following:

      i. 36400-36425
      ii. 36511-36515
      iii. 38204-38215
      iv. 70000-79999
      v. 80000-89999
      vi. 90281-90799
      vii. D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0321, D0330, D0460, D0501
      viii. All J codes
      ix. P3000-P3001
      x. All Q codes
      xi. All S codes (**except** S9436 and S9445-S9470 [inclusive])

Services provided to clients in state-only programs and reimbursed separately by the state do not qualify for a Medicaid encounter. Clients identified in ProviderOne with one of the following medical coverage group codes are enrolled in a state-only program:

For services provided to clients in programs ineligible for encounters, bill using the center's fee-for-service NPI along with the billing and/or servicing taxonomy for the type of service performed. The agency does not pay the encounter rate or the enhancement for clients enrolled in these programs (see the following table).

FQHC clients identified in ProviderOne with one of the following medical coverage group codes and associated recipient aid category (RAC) code(s) do **not** qualify for the encounter rate or the enhancement:

Medical Coverage Group Codes	RAC Code
F06	RACs 1138, 1139 only
F07	RACs 1141, 1142 only
F99	RAC 1040
G01	RACs 1041, 1135-1137, 1145 only
I01	RAC 1050, 1051 only
K03	RACs 1056,1058, 1176-1178 only
K95	RACs 1060, 1064, 1179-1181 only
K99	RACs 1060, 1064, 1179-1181 only
L04	RACs 1077, 1078, 1081, 1082, 1158-1161, 1182-1185 only
L24	RACs 1190-1195 only
L95	RACs 1085, 1087, 1155, 1157, 1186, 1187 only
L99	RACs 1085, 1087, 1090, 1092, 1155, 1157, 1186-1189
M99	RAC 1094 (This is the only RAC for M99)
P05	RAC 1097, 1098 only
P06	All RACs (1099-1100)
S95	RACs 1125, 1127
S99	RACs 1125, 1127
W01	All RACs (1128, 1129, 1170, 1171)
W02	All RACs (1130, 1131, 1172, 1173)
W03	RAC 1132 (This is the only RAC for W03)

Services provided to clients with the following medical coverage group code and RAC code combinations are eligible for encounter payments effective for dates of service on or after October 1, 2009.

Medical Coverage Group Codes	RAC Code
K03	RAC 1057 (This is not the only RAC for K03.)
K95	RAC 1062 (This is not the only RAC for K95.)
K99	RAC 1062 (This is not the only RAC for K99.)
P04	RAC 1096 (This is the only RAC for P04.)
P99	RAC 1102 (This is the only RAC for P99.)

What Types of Services Do *NOT* Qualify as Encounters?

The following are examples of services not reimbursed as an encounter. These services are reimbursed fee-for-service.

- Blood draws, laboratory tests, x-rays, prescriptions, and/or optical services. These are not encounters, but these procedures may be provided in addition to other medical services as part of an encounter.
- The administration of drugs and biologicals, including pneumococcal and influenza vaccines and other immunizations.
- Delivery and postpartum services provided to pregnant undocumented alien S women.
- Health services provided to clients under state-only programs, as listed on the previous page.

Note: As client eligibility may change, bill encounter code T1015 on claims for *all* eligible services. ProviderOne will determine whether the encounter is payable when the claim is processed.

What FQHC-Related Activities Are *NOT* Covered by the agency?

The following circumstances are ***NOT*** covered by the agency and ***CANNOT*** be billed either as an encounter or on a fee-for-service basis:

- Participation in a community meeting or group session that is **not** designed to provide health services.

Examples:	Informational sessions for prospective users, health presentations to community groups, high school classes, PTAs, etc. or, informational presentations about available FQHC health services.

- Health services provided as part of a large-scale effort.

Examples:	Mass-immunization program, a screening program, or a community-wide service program (e.g., a health fair).

Categories of Encounters

Encounters may be reported for each of the five permitted cost centers. Those cost centers are:

- Medical/Maternity
- Maternity Support Services/Infant Case Management
- Dental
- Mental Health
- Chemical Dependency

Medical/Maternity Encounter

A medical/maternity encounter is a face-to-face encounter between a medical provider and a client during which services are provided for the prevention, diagnosis, treatment and/or rehabilitation of illness or injury, or for prenatal care and/or delivery. Included in this category are physician encounters and mid-level practitioner encounters, and encounters by psychiatrists, psychiatric ARNPs, psychologists, and qualified clinical social workers who are not performing community mental health. **An encounter code and its related fee-for-service code(s) must be billed on the same claim form.**

Physician Encounter: A face-to-face encounter between a physician and a client. Psychiatrist and approved Diabetes Education Program encounters are included in this category.

Mid-level Practitioner Encounter: A face-to-face encounter between a mid-level practitioner (Advanced Registered Nurse Practitioner [ARNP], Certified Nurse Midwife, Licensed Midwife, Woman's Health Care Nurse Practitioner, Physician's Assistant [PA], or psychiatric ARNP) and a client, in which the mid-level practitioner acts as an independent provider. Services provided by registered nurses are not encounters.

Medical Mental Health Benefit: Children age 18 and younger who do not meet the Regional Support Network (RSN) Access to Care Standard may receive mental health encounters through one of the following Benefit Service Packages:

- Categorically Needy Program (CNP);
- State Children's Health Insurance Program (SCHIP); or
- Limited Casualty – Medically Needy Program (LCP-MNP).

For clients 18 years of age and younger, the agency will pay providers for one psychiatric service per day, up to a maximum of 20 encounters, including the evaluation, per eligible client, per calendar year for the expanded services listed in the current Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide. This may include some hours delivered by one provider and other hours delivered by another provider.

The following list of mental health professionals, as defined in RCW 71.34.020 and licensed by the Department of Health, may provide and bill the agency fee-for-service for expanded mental health services to children:

- **Psychiatrist:** Licensed Psychiatrist;
- **Psychologist:** Licensed Psychologist;
- **Psychiatric Nurse:** Licensed Advanced Registered Nurse Practitioner;
- **Social Worker:** Licensed Independent Clinical Social Worker or Advanced Social Worker;
- **Marriage and Family Therapist:** Licensed Marriage and Family Therapist; and
- **Mental Health Professionals:** Licensed Mental Health Counselor.

> **Note:** Mental health professionals must meet the provider requirements listed in the Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide.

The agency limits outpatient psychotherapy and electroconvulsive therapy in any combination for clients 19 years of age and older to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy. Pharmacological management is not subject to the 12-visit limitation for psychiatrists. The agency does not pay psychiatric ARNPs for psychotherapy for adults 21 and over. The agency pays one psychiatric diagnostic interview examination 90801 or 90802 once a calendar year.

Centers should bill a medical encounter when providing mental health services to clients who do not meet the RSN Access to Care Standard. For these clients, the FQHC may bill medical encounters ***only*** when provided by psychiatrists, psychologists, or clinical social workers as

detailed in the "Psychiatric Services" section of the current Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide. Bill these medical encounters using HCPCS code T1015 and the appropriate medical NPI and taxonomy (see How Do I Bill Taxonomy Codes? for more information). Encounters are subject to the same service limitations detailed in those billing instructions.

Maternity Support Services/Infant Case Management Encounter

For an FQHC to submit encounters and include costs for MSS/ICM in cost reports, the agency must be approved by the Department of Health, and must meet the billing policy and eligibility requirements as specified in the current *Maternity Support Services (MSS)/Infant Case Management (ICM) Medicaid Provider Guide.*

A maternity support services encounter is a face-to-face encounter between a MSS/ICM provider and a client during which MSS/ICM services are provided.

MSS includes assessment, development, implementation and evaluation of plans of care for pregnant women and their infants for up to two months postpartum. **An encounter code and its related fee-for-service code(s) must be billed on the same claim form.**

MSS/ICM Encounter: An encounter between a member of the MSS/ICM interdisciplinary team and the client. Team members must meet specific program qualifications and may include a community health nurse, behavioral health specialist, registered dietitian, or a community health worker. Refer to the current *Maternity Support Services (MSS)/Infant Case Management (ICM) Medicaid Provider Guide* for specific qualifications.

> **Note:** Separate documentation must be in the client's file for each type of service provided by a mid-level practitioner.

The agency allows more than one maternity support services encounter, per day, per client, provided they are:

- Different types of services,
- Performed by different practitioners; and
- Billed on separate claim forms.

Dental Encounter

For an FQHC to submit encounters and include costs for dental in cost reports, the agency must be approved by the agency and must meet the billing and eligibility requirements as specified in the current *Dental Program for Clients Age 21 and Older Medicaid Provider Guide* and *Dental Program for Clients Through Age 20 Medicaid Provider Guide*.

A dental encounter is a face-to-face encounter between a dentist or a dental hygienist and a client for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. **Only one encounter is allowed per day.**

> **Note:** A dental hygienist may bill an encounter only when he/she provides a service independently - **not** jointly with a dentist. Only **one** encounter per day at a dental clinic is covered.

> **Exception:** When a dental service requires multiple visits (e.g., root canals, crowns, dentures), an encounter code must be billed with the number of visits, when the dental services are complete.

Mental Health Encounter

To provide mental health services that qualify under this separate cost center, the agency must be a licensed community mental health center and have a contract with a Regional Support Network (RSN). Included in this category are mental health professionals, as defined by RCW 71.34.020. The mental health RSN program is **mandatory for Medicaid clients who are enrolled in an RSN and meet the RSN Access to Care Standard**.

> **Note:** Refer to Medical/Maternity Encounter for clients who do not meet the RSN Access to Care Standard.

A mental health encounter is a face-to-face visit between a mental health provider and a client during which services are provided for the diagnosis and treatment of a Diagnostic and Statistical Manual-3 (DSM-3R) psychiatric condition.

Psychiatrist and Psychologist Services: An encounter between a client and a physician or osteopath licensed under chapter 18.57 or 18.71 RCW, who is board-eligible in psychiatry or a psychologist licensed under chapter 18.83 RCW.

Mid-level Practitioner Services: An encounter between a mid-level practitioner and a client in which the mid-level practitioner acts as an independent provider. A mid-level practitioner is:

a. A psychiatric nurse, which means a registered nurse licensed under chapter 18.88 RCW and who has at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional.

b. A social worker, which means a person with a master's or further advanced degree from an accredited school of social work or a degree from a graduate school considered equivalent by the agency director.

c. A person who has at least a master's degree in behavioral sciences, nursing sciences, or related field from an accredited college or university and who has at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional.

d. A mental health counselor or marriage and family therapist certified under chapter 18.19 RCW and who has at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional; OR

e. A person who has at least a bachelor's degree in behavioral sciences or related field from an accredited college or university and who has at least five years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional.

Chemical Dependency Treatment Programs

An FQHC treatment facility must be approved by the agency according to Chapter 440-22 WAC and RCW 70.96A. FQHCs may submit encounters and include costs in cost reports for only those services as listed in the current *Chemical Dependency Medicaid Provider Guide*.

A chemical dependency encounter is a face-to-face visit between a medical provider and/or Qualified Chemical Dependency Counselor (QCDC), as defined in WAC 440-22-200 through 250, and a client, during which services are provided for outpatient alcohol and drug treatment services.

Reimbursement

When Does the agency Pay for FQHC Services?

[WAC 182-548-1300 (2)]

The agency pays for FQHC services when they are:

- Within the scope of an eligible client's medical assistance program. Refer to WAC 182-501-0060 scope of services; and
- Medically necessary as defined WAC 182-500-0005.

The Reimbursement Structure

The FQHC reimbursement structure is encounter-based. Facility-specific encounter rates are established for each FQHC and are paid for services eligible for an encounter payment. Services not eligible for an encounter payment are paid at the appropriate fee schedule amount.

Washington Medicaid bases FQHC reimbursement on the CMS-approved Medicaid State Plan. CMS only permits reimbursement based upon reasonable costs for services defined in the Washington Title XIX State Plan or as defined in Section 1861 (aa)(1) (A) – (C) which lists FQHC-required core services. Reimbursement is not permitted for costs for health care or services not in the Washington Title XIX State Plan or as defined in the FQHC core services.

In Washington State, FQHCs have the choice of being reimbursed under the Prospective Payment System (PPS) as outlined in the Benefits Improvement and Protection Act of 2000 (BIPA) statutory language, or an Alternative Payment Methodology (APM).

- For information on how the agency calculates the PPS encounter rate, refer to **WAC 182-548-1400 (3) and (4)**.
- For information on how the agency calculates the APM encounter rate, refer to **WAC 182-548-1400 (5)**.

Payment for Services Eligible for an Encounter

The agency pays centers for services eligible for an encounter on an **encounter rate** basis rather than a FFS basis.

All FQHC services and supplies incidental to the provider's services are included in the encounter rate payment. **[WAC 182-548-1400 (7)]**

The agency limits encounters to one per client, per day, except in the following circumstances:

- The visits occur with different healthcare professionals with different specialties; **or**
- There are separate visits with unrelated diagnoses. **[WAC 182-548-1400 (6)]**

> **Note:** The service being performed must require the skill and ability of an encounter-level practitioner as described in Cost Reporting Requirements in order to qualify for an encounter payment.

The agency pays encounters as follows:

- The amount owed (the number of encounters indicated on the paid claim forms multiplied by the encounter rate); and

- The amount reimbursed based on the fee-for-service methodology.

For example:	$150.00	Medical Encounter Rate
	x 1	# of Medical Encounters for Claim
	= **$150.00**	**Total Amount Due**
	$150.00	
	-$75.00	**Fee-for-Service Paid**
	= **$75.00**	**Encounter Amount Paid**

Payment for Services Not Eligible for an Encounter

[Refer to WAC 182-548-1400 (8)]

Payments for nonFQHC services provided in an FQHC are made on a fee-for-service basis using the agency's published fee schedules. **For information on FFS reimbursement,** refer to the appropriate Agency billing instructions, located at http://hrsa.dshs.wa.gov/billing/bi.html.

Choice of Rates

FQHCs may choose to have:

1) An all-inclusive rate, which covers all encounter services;

2) Individual rates for each of the five permitted cost centers; or

3) A grandfathered rate structure consistent with the rate structure used for PPS rate development.

For FQHCs choosing an all-inclusive rate, this rate will be applied to each of the cost centers. For FQHCs choosing the individual rate option, the rates will be weighted and applied according to the appropriate cost centers.

Those cost centers are:

- Medical/Maternity (**Note:** Maternity encounters are reported separately from medical encounters.) This cost center includes all medical mental health encounters for individuals not meeting the RSN Access to Care standards.
- Maternity Support Services/Infant Case Management.
- Dental.
- Mental Health. This cost center includes only costs for centers contracting with an RSN.
- Chemical Dependency.

Supplemental Payments for Managed Care Clients

[Refer to WAC 182-548-1400 (9)-(11)]

For clients enrolled with a Managed Care Organization (MCO), covered FQHC services are paid for by that plan.

Only clients enrolled in Title XIX (Medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The agency does not pay the encounter rate or the enhancement rate for clients in state-only medical programs. Services provided to clients in state-only medical programs are considered fee-for-service regardless of the type of service performed.

Enhancement Payments for Managed Care Clients

For clients enrolled with an MCO, the agency pays each FQHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a(bb)(5)(A). These enhancements are intended to make up the difference between the MCO payment and a center's encounter rate.

The HO enhancements are not billed by the centers; payments are generated from client rosters submitted to the agency by the MCOs. Payment is sent directly to the FQHCs.

The FQHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

To ensure that the appropriate amounts are paid to each FQHC, the agency performs an annual reconciliation of the enhancement payments. For each FQHC, the agency will compare the amount actually paid to the amount determined by the following formula:

(Managed care encounters times encounter rate) less FFS equivalent of MCO services

If the center has been overpaid, the agency will recoup the appropriate amount. If the center has been underpaid, the agency will pay the difference.

> **Note:** FQHCs no longer get paper Remittance Advice (RA). To access detailed payment information, FQHCs must access ProviderOne. See the ProviderOne Companion Guide for more information.

FQHC Delivery Enhancement Payments

The agency makes a payment to the center when a qualified FQHC provider performs a delivery for a managed care client assigned to the center. This payment is known as the "delivery enhancement." If ProviderOne indicates the client is enrolled in BHP+ at the time of delivery, the agency pays the center an additional payment for the delivery known as the "S-kicker enhancement."

The agency pays a center a delivery enhancement and, if applicable, the S-kicker enhancement only when either of the following scenarios is met:

1. The FQHC provider **actually performs the delivery and the FQHC** (or any provider under the same tax ID as the FQHC) **is the client's assigned Primary Care Provider (PCP).**

The agency does not pay a delivery enhancement for a managed care client assigned to the FQHC when a provider who is not affiliated with the client's assigned center performs the delivery or when the FQHC provider only assists at delivery.

-OR-

2. The **FQHC** (or any provider under the same tax ID as the FQHC) **is the client's assigned Primary Care Provider (PCP) and the FQHC is fully financially liable for the cost of the delivery**.

To be considered fully financially liable, the FQHC must pay the provider who performs the delivery 100% of the cost of the delivery from its own funds. Participation in "risk pools" **does not** constitute being fully financially liable. The FQHC Program Manager will review the FQHC's contract with the managed care organization in order to determine

whether the FQHC is fully financially liable. The agency will not pay a delivery or S-kicker enhancement without this determination **and** prior approval from the FQHC Program Manager.

Do not bill the agency to receive the service-based enhancements. The payments are automatically generated based on managed care encounter data submitted to the agency by the MCOs. If the appropriate requirements are met, the delivery enhancement will be paid directly to the center. In order for this automatic payment to be triggered, the same NPI must be:

- Used by the center when billing deliveries to the MCO(s);
- Used by the MCO(s) on the monthly enhancement file sent to the agency; and
- Submitted by the MCO(s) to the agency in the managed care encounter data.

If delivery enhancements appear to be missing or incorrect, please contact the appropriate MCO.

Under What Circumstances Does the agency Change FQHC Payment Rates (Change in Scope of Service)?

[Refer to WAC 182-548-1500]

Centers Reimbursed Under the Prospective Payment System (PPS)

- For centers reimbursed under the Prospective Payment System (PPS), the agency considers an FQHC change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the FQHC. Changes in scope of service apply only to covered Medicaid services.

  Note: A change in costs alone does not constitute a change in scope of service.

- When the agency determines that a change in scope of service has occurred after the base year, the agency adjusts the FQHC's encounter rate to reflect the change.

- FQHCs must:

  ✓ Notify the agency's FQHC Program Manager in writing (see Important Contacts) of any changes in scope of service **no later than 60 calendar days** after the effective date of the change; and

- ✓ Provide the agency with all relevant and requested documentation pertaining to the change in scope of service.

- The agency adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

  - ✓ A Medicaid comprehensive desk review of the FQHC's cost report;
  - ✓ Review of a Medicare audit of the FQHC's cost report; or
  - ✓ Other documentation relevant to the change in scope of service.

- The adjusted encounter rate will be effective on the date the change of scope of service is effective.

Centers Reimbursed Under the Alternative Payment Methodology (APM)

- For centers reimbursed under the Alternative Payment Methodology (APM), the agency considers an FQHC change in scope of service to be a change in the type of services provided by the FQHC. Changes in intensity, duration, and/or amount of services will be addressed in the next scheduled encounter rate rebase. Changes in scope of service apply only to covered Medicaid services.

Note: A change in costs alone does not constitute a change in scope of service.

- When the agency determines that a change in scope of service has occurred after the base year, the agency adjusts the FQHC's encounter rate to reflect the change.

- FQHCs must:

  - ✓ Notify the agency 's FQHC Program Manager in writing (see Important Contacts) of any changes in scope of service **no later than 60 calendar days** after the effective date of the change; and

  - ✓ Provide the agency with all relevant and requested documentation pertaining to the change in scope of service.

- The agency adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

  - ✓ A Medicaid comprehensive desk review of the FQHC's cost report; or
  - ✓ Other documentation relevant to the change in scope of service.

- The adjusted encounter rate will be effective on the date the change of scope of service is effective.

Note: Beginning in 2013, all APM encounter rates will be rebased every four years.

Note: If the costs of an FQHC service are captured on a center's cost report and are included in the calculation of the encounter rate, those services must be billed as FQHC services.

Are FQHC Liable for Payments Received?

Each FQHC is individually liable for any payments received and must ensure that it receives payment for only those situations described in these and other applicable billing instructions. FQHC claims are subject to audit, and FQHCs are responsible to repay any overpayments.

Upon request, complete and legible documentation must be made available to the agency that clearly documents any services for which the FQHC has received payment.

Cost Reporting Requirements

The following regulations and policies are the standards applicable to the FQHC cost reports used for the alternative payment methodology (APM) rebasing:

- 42 CFR Section 413;
- Agency policies and definitions including all billing instructions;
- Circular A-122 "Cost Principles for Nonprofit Organizations;" and
- Medicare Provider Reimbursement Manual (MPRM).

What Are Allowable Costs?

Allowable costs are documented costs as reported after any cost adjustment, cost disallowances, reclassifications, or reclassifications to non-allowable costs which are necessary, ordinary and related to the outpatient care of medical care clients and are not expressly declared non-allowable by applicable statutes or regulations. Costs are ordinary if they are of the nature and magnitude which prudent and cost-conscious management would pay.

What Are Allowed Direct Healthcare Costs?

Direct health services costs must be directly related to patient care and identified specifically with a particular cost center.[2]

All services must be furnished by providers authorized to provide Medicaid State Plan services. Services and medical supplies "incident to" professional services of health care practitioners are those commonly furnished in connection with these professional services, generally furnished in a physician or dentist's office and ordinarily rendered without charge or included in the practice bill, such as ordinary medications and other services and medical supplies used in patient primary care services. "Incident to" services must be furnished by a center employee and must be furnished under the direct, personal supervision of the health care practitioner, meaning that the health care practitioner must be physically present in the building and immediately available for consultation.

[2] Direct cost of minor amounts may be treated as indirect costs as described below. Because of the diverse characteristics and accounting practices of non-profit organizations, it is not possible to specify the types of cost which may be classified as direct and indirect cost in all situations. However, typical examples of indirect cost for many non-profit organizations may include depreciation or use allowances on buildings and equipment, the costs of operating and maintaining facilities, and general administration and general expenses, such as the salaries and expenses of executive officers, personnel administrators, and accounting staff.

FQHC core services include those professional services provided in the office, other medical facility, the patient's place of residence (including nursing homes) or elsewhere, but not the institutional costs of the hospital, nursing facility, etc. Core services are covered for Medicaid patients. For example, the State must cover services provided in an appropriately licensed FQHC by psychologists (either under the medical mental health benefit for individuals not meeting the regional support network (RSN) Access to Care standards or as a mental health visit for RSN-eligible children or adults who do meet the standards) because they are core services.

The following services are covered; costs for these services provided to Washington Medicaid beneficiaries may be included in the cost report:

- **Preventive services** – To the extent covered in Washington statute and administrative code.

- **FQHC core services** –

  - ✓ Physician services, including costs for contracted physician services, to the extent covered in Washington statute and administrative code. Contracted physicians must be identified in the FQHC's Core Provider Agreement. The contracted physician must be a preferred provider and receive an identification number from the Provider Enrollment Section at the agency.

  - ✓ Mid-Level Practitioner (PAs, ARNPs and CNMs) services – To the extent covered in Washington statute and administrative code, including costs for contracted mid-level practitioner services.

  - ✓ Clinical Psychologist services – Per the medical mental health benefit for individuals not eligible for the RSN Access to Care Standards OR the mental health benefit for services provided through an RSN contract for individuals meeting the RSN Access to Care Standards.

  - ✓ Licensed Clinical Social Worker services (LCSWs) – Per the medical mental health benefit for individuals not eligible for the RSN Access to Care Standards OR the mental health benefit for services provided through an RSN contract for individuals meeting the RSN Access to Care Standards.

  - ✓ Visiting Nurse Home Health services (in designated areas where there is a shortage of home health agencies) – To the extent covered in Washington statute and administrative code.

- **Hospital Care** – The physician/professional component performed by center practitioners in outpatient, inpatient, emergency room or swing bed facilities of a hospital (i.e., physicians' services for OB) as covered in the State Plan. Note: Institutional facility and overhead costs are excluded from FQHC cost reports and billed separately by the institution.

- **Nursing Home Care** – The professional component only as covered in Washington statute and administrative code.

- **Other Ambulatory Services** – Claims as submitted using the FFS claim and billing instructions and FQHC reimbursement instructions for:

  ✓ Blood draws;

  ✓ Laboratory tests;

  ✓ X-rays;

  ✓ Pharmacy (**Note:** Pharmacy service costs that are not "referred services" or subcontracted services and are reimbursable under the Medicaid State Plan would be included under direct costs in the cost reports including 340B costs directly incurred by the center. FQHCs should continue to claim pharmacy reimbursement under the FFS pharmacy program. All pharmacy costs should be included in the medical/maternity cost center of the cost report, including PharmD prescribing); and

  ✓ Optical services.

- **Other Ambulatory services** – Encounters and claims submitted through separate cost centers or as part of the all-inclusive rate per instructions in Encounters:

  ✓ Dental

Note: All policy references in this section to medical services include dental services as covered under Washington statute and administrative code.

  ✓ Other mental health practitioners eligible under the medical mental health benefit for individuals not meeting the RSN Access to Care standards (under the medical/maternity cost center only).

- **Diabetes Self-Management Training Services and Medical Nutrition Therapy services** – To the extent covered in Washington statute and administrative code.

- **EPSDT**.

- Paper medical record costs including pharmacy and dental records. Because there is new funding available for electronic medical records (EMR) under the American Recovery and Reinvestment Act (ARRA stimulus package), all funds, credits and grants to pay for EMR should be reflected on the cost report and offset against appropriate costs. Only the unreimbursed portion of EMR is allowable. EMR costs that are not capitalized, such as monthly service costs, are allowable in Allowable Direct Service Costs. Hardware,

software and other EMR costs meeting MPRM CMS Publication 15-1 capitalization requirements must be capitalized and depreciated (net of credits, grants, etc.); the allowable depreciation may be included in Allowable Direct Service Costs. FQHCs will place the depreciation of electronic medical records (EMR) into Allowable Direct Service Costs to result in a similar treatment of EMR to paper records and medical equipment that allows for the non-payment of costs of EMR unrelated to Medicaid.

What Are Unallowable Direct Health Services Costs?

The agency pays an encounter rate only for services provided to an eligible Washington Medicaid beneficiary. Encounters for any individual other than an eligible Washington Medicaid beneficiary are not reimbursed, including any out-of-state Medicaid, Medicare, private pay or uninsured individual. Costs for services, provided to Medicaid beneficiaries, that are not required by the Department of Health and Human Services and/or not included in state statute or administrative code, are unallowable, including but not limited to:

- **Mental health services** outside of the RSN contract for individuals meeting the RSN Access to Care Standards.

- **Women, Infants and Children (WIC) Program** – the agency reimburses for nutritional assessments and/or nutritional counseling in the WIC program only when the service is part of the EPSDT program. Costs for nutritional assessment and/or nutritional counseling are allowed under the following circumstances only:

  - ✓ **Children's Initial Nutritional Assessment:** The WIC program requires an initial assessment. If an initial health assessment is performed by an EPSDT provider, this information may be used to complete the paperwork for the WIC assessment instead of WIC repeating the process. The agency reimburses for this service when performed as part of an EPSDT screening.

  - ✓ **Children's Second Nutrition Education Contact:** The WIC program requires a second nutrition education contact that is reimbursed by WIC funds. If the child is determined to be at nutrition high-risk, WIC requires that a nutrition high-risk care plan be written. The nutrition high-risk care plan, if written by the certified dietitian through an EPSDT referral, may be used to meet the requirement of the WIC nutrition high-risk care plan. The agency reimburses for nutritional counseling only when it is part of an EPSDT referral.

  - ✓ **Pregnant Women Assessment:** Pregnant women in the WIC program are required to have an initial assessment and a second nutrition education contact, which are reimbursed by WIC funds. If additional nutritional counseling is required and performed as part of Maternity Support Services (MSS), the agency reimburses for the additional nutritional counseling.

- **Staff education**, except for training and staff development, required to enhance job performance for employees of the FQHC. Student loan reimbursements are considered to be unallowable education expenses.

- **Beneficiary outreach and outreach to potential clients**, except for the following type of activities: informing the target population of available services, such as via telephone yellow pages, brochures, and handouts. Excluded outreach costs include but are not limited to advertising, participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services.

- **Assisting other health care professionals** in the provision of off-site training, such as dental screening, blood pressure checks, etc.

- **Public relations** dedicated to maintaining the image or maintaining or promoting understanding and favorable relations with any segment of the public. For example, costs of meetings, conventions, convocations, or other events related to non-Medicaid activities of the non-profit organization, including: costs of displays, demonstrations, and exhibits; costs of meeting rooms, hospitality suites, and other special facilities used in conjunction with shows and other special events; and salaries and wages of employees engaged in setting up and displaying exhibits, making demonstrations, and providing briefings; costs of promotional items and memorabilia, including models, gifts, and souvenirs; and costs of advertising and public relations designed solely to promote the non-profit organization.

- **Community services**, such as health presentations to community groups, PTAs, etc.

- **Environmental activities** designed to protect the public from health hazards such as toxic substances, contaminated drinking water and shellfish.

- **Research**.

- **Costs associated with the use of temporary health care personnel** from any nursing pool not registered with the Department of Licensing at the time of such personnel use.

- **Costs for subcontracted services** (referred services) other than subcontracted physicians and mid-level practitioners. For example: costs for laboratory, x-ray, and pharmacy subcontracts the center has for the performance of support services. The laboratory, x-ray facility or pharmacy bills the agency directly and is reimbursed directly by the agency.

- **Institutional services** such as hospital care, skilled nursing care, home health services, rehabilitative services, inpatient or outpatient mental health services that are provided on an inpatient or outpatient basis, excluding the professional component (which may be included in the cost report).

- **Services that are not directly provided by the center**.

- **Services by alternative providers** not covered in the Washington Medicaid State Plan (i.e., acupuncturists).

- **Transportation costs** – Transportation costs will not be included in the cost report and the trip does not result in an encounter being billed.

What Are Allowable Uncapped Overhead Costs?

Overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Overhead costs that are allocated must be clearly distinguished from other functions and identified as a benefit to a direct service. Costs that can be included in the Uncapped Overhead cost center are:

- **Space costs**, which are defined as building depreciation, mortgage interest, and facility lease costs. The FQHC is required to have a reasonable floor space allocation plan that adequately documents facility usage. At least 25% of the facility must be used for a direct cost function (i.e., medical). Depreciation in the Medicaid cost report must be consistent with that claimed on the center's Medicare cost report. Guidelines may be found in the Medicare Provider Reimbursement Manual CMS publication 15-1.

- **Billing Agency costs** that are separate and distinct functions of the FQHC for the purpose of billing for medical care only. Staff must be solely dedicated to medical billing and duties must be assigned in advance.

- **Medical receptionist, program registration, and intake costs**.

- **Non medical supplies, telephones, Electronic Practice Management, and copy machines**.

- **Dues for personnel to professional organizations** that are directly related to the individual's scope of practice. **Limited to one professional organization per professional**.

- **Utilization and referral management costs**.

- **Credentialing**.

- **Clinical management costs.**

What Are Allowable Capped Overhead Costs?

The State will impose a cap for the Capped Overhead cost center. As determined using the methodology outlined below, the cap will be a certain percentage of direct health care costs. The following are examples of Capped Overhead costs:

- **Billing Agency expenses** that do not meet the definition under Uncapped Overhead.

- **Space costs** that do not meet the definition under Uncapped Overhead. The FQHC will utilize its Medicare depreciation schedule for all items and maintain documentation of that schedule for Medicaid auditors.

- **Dues to industry organizations –** These are limited to:

  ✓ Those dues that are not grant-funded or used by organizations for lobbying activities; and
  ✓ **One industry organization per center**.

  Note: This includes membership in business, technical, and professional organizations.

- **Costs associated with employees** who verify fee-for-service and managed care eligibility.

- **Data processing expenses** (not including computers, software or databases not used solely for patient care or center administration purposes).

- **Finance and Audit Agency costs.**

- **Human Resources Agency costs.**

- **Administration and disaster recovery and preparedness costs.**

- **Facility and phone costs** for outstationed financial workers provided by Community Service Offices (CSO). Any revenues received from a CSO for facility and other costs must also be recorded as an offset to the expense in the cost report.

- **Per Circular OMB A-122, maintenance costs** incurred for necessary maintenance, repair or upkeep of buildings and equipment (including federal property, unless otherwise provided for), which neither add to the permanent value of the property nor appreciably prolong its intended life, but keep it in an efficient operating condition. Costs incurred for improvements which add to the permanent value of the buildings and equipment or appreciably prolong their intended life are treated as capital expenditures.

- **Per Circular OMB A-122, security costs** and necessary and reasonable expenses incurred for routine and homeland security to protect facilities, personnel, and work products. Such costs include, but are not limited to:

  ✓ Wages and uniforms of personnel engaged in security activities;
  ✓ Equipment;
  ✓ Barriers;
  ✓ Contractual security services; and
  ✓ Consultants.

What Are Unallowable Overhead Costs and Other Expenses?

Unallowable costs as noted in 42 CFR 413 are unallowable in the Washington cost report. Additional unallowable overhead costs and other expenses include, but are not limited to, the following:

- **Costs not related to patient care.**

- **Indirect costs allocated to unallowable direct health service costs** – These are also unallowable per Circular OMB A-122. The costs of certain activities are unallowable as charges to federal awards (e.g., fundraising costs). However, even though these costs are unallowable for purposes of computing charges to federal awards, a share must be allocated to the organization's indirect costs if they represent activities which:

  ✓ Include the salaries of personnel;
  ✓ Occupy space; and
  ✓ Benefit from the organization's indirect costs.

- **Entertainment** (e.g., office parties/social functions, costs for flowers, cards for illness and/or death, retirement gifts and/or parties/social functions, meals and lodging). This includes:

  ✓ Amusement;
  ✓ Diversion; and
  ✓ Social activities and any costs directly associated with such costs (such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities).

  These costs are unallowable and cannot be included as a part of employee benefits.

- **Board of Director Fees** – Travel expenses related to mileage, meal and lodging for conferences; and registration fees for meetings not related to operating the center (e.g., center-sponsored annual meetings, retreats, and seminars). Allowable travel would include

attending a standard Board of Directors' meeting. The reimbursement level for allowed travel is based on the lesser of actual costs or state travel regulations.

- **Federal, state, and other income taxes and excise taxes.**
- **Medical Licenses** – Costs of medical personnel professional licenses.
- **Donations, services, goods and space** except those allowed in Circular A-122 and the MPRM.
- **Fines and penalties.**
- **Bad debts**, including losses (whether actual or estimated), arising from uncollectable accounts and other claims, related collection costs, and related legal costs.
- **Advertising,** except for the recruitment of personnel, procurement of goods and services, and disposal of medical equipment and medical supplies.
- **Contributions to a contingency reserve** or any similar provision made for events, the occurrence of which cannot be foretold with certainty as to time, intensity, or with an assurance of their happening. The term "contingency reserve" excludes self-insurance reserves, pension funds, and reserves for normal severance pay.
- **Over-funding contributions to self-insurance funds** that do not represent payments based on current liabilities. Self-insurance is a means by which a provider independently or as part of a group undertakes the risk of protecting itself against anticipated liabilities by providing funds in an amount equal to anticipated liabilities, rather than by purchasing insurance coverage. Accrued liabilities related to contributions to a self-insurance program that are systematically made to a funding agency and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.
- **Legal, accounting, and professional services** incurred in connection with hearings and re-hearings, arbitrations, or judicial proceedings against the agency. This is in addition to the unallowable costs listed for similar costs in connection with any criminal, civil or administrative proceeding in A-122.
- **Fund raising costs.**
- **Amortization of goodwill.**
- **Membership dues for public relations,** except for those allowed as a direct health care covered cost or overhead cost. For example, costs of membership in any civic or community organization, country club, or social or dining club or organization are unallowable.

- **Political contributions and lobbying expenses** or other prohibited activity under A-122.

- **Costs allocable to the use of a vehicle or other company equipment for personal use**, as well as any personal expenses not directly related to the provision of covered services; mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel; or out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses that increase the quality of medical care or the operating efficiency of the FQHC.

- **Costs applicable to services, facilities and supplies furnished by a related organization** in excess of the lower of cost to the related organization or the price of comparable service. Circular A-122 addresses consulting directly related to services rendered.

- **Vending machine expenses.**

- **Charitable contributions.**

- **Personnel costs for outstationed financial workers** provided by Community Service Offices (CSO). The CSO makes the final decision on whether or not to outstation CSO staff based on an evaluation of the level of Medicaid activity and resources available. When CSO staff are outstationed in an FQHC, a written agreement between the CSO and the FQHC spelling out the responsibilities of each is required. Any revenues received as reimbursement for CSO staff expenses must be recorded in the cost report.

- **Interpreter services.** Do not include interpreter services costs in the cost report or bill them as an encounter.

- **Restricted grants.** Grants for specific purposes are to be offset against allowable expenses including costs paid for by specific grants or contributions (e.g., supplies, salaries, equipment, etc.) This does not include grants received under Section 330 of the Public Health Services Act. When a provider receives a payment from any source prior to the submission of a claim to the agency, the amount of the payment must be shown as a credit on the claim in the appropriate field.
- **Unallowable costs** noted in 42 CFR 413, Circular A-122 and the Medicare Reimbursement Manual (MPRM).

What Are Requirements for Cost Reports?

Complete the Washington Medicaid cost reports consistent with the Washington FQHC Cost Report Instructions. The cost report starts with the A-133 audited working trial balance and has five cost centers:

- Medical/Maternity;
- Maternity Support Services/Infant Case Management;

- Dental;
- Mental Health; and
- Chemical Dependency.

APM rates for services calculated on the basis of these cost reports are FQHC-wide and apply to all sites. The FQHC must select a rate structure that is one of the following:

- An all-inclusive rate;

- A separate rate for each of the five cost-centers; or

- A grandfathered rate structure consistent with the rate structure used for PPS rate development. Definitions of the encounters are consistent with the cost center definitions.

Encounters are defined in a consistent manner with historical encounters to ensure the comparability of the APM to historic PPS encounter rates (i.e., increasing the encounters in the APM calculation would cause the APM PPS to deflate, allowing the centers to claim the higher historic PPS for a larger number of encounters).

Corporations with multiple sites may be designated as a single FQHC or each site may be an individual FQHC, depending on the designation by CMS and the Public Health Service.

Desk Reviews and Audits

- **Standards** – The following regulations are the audit standards applicable to the FQHC cost reimbursement program in order of precedent:

  - ✓ 42 CFR Section 413;
  - ✓ Agency policies and definitions;
  - ✓ Circular A-122 “Cost Principles for Nonprofit Organizations;” and
  - ✓ Medicare Provider Reimbursement Manual.

- **Documentation** – Documentation must be available for the auditors in the client’s medical record at the center. Separate maternity and medical records must not be kept at different locations. Until a chart is established for a newborn, when a physician sees the baby, this encounter must be clearly documented in the mother’s record.

- **Exceptions** – There is no standard exception audit policy but providers are allowed to ask for case-by-case exceptions.

Submission Requirements

The agency obtains a copy of the audited Medicare cost reports from the CMS contracted firm that audits the cost reports.

- **Rebasing** – FQHCs reimbursed under the APM have the option to rebase their encounter rate in 2010. Each FQHC that chooses to rebase in 2010 is required to submit the Medicaid FQHC cost report that corresponds with the fiscal year in the most recent audited A-133 trial balance consistent with the Cost Report Instructions. Beginning in 2013 and every four years thereafter, the encounter rates of every FQHC reimbursed under the APM will be mandatorily rebased.

  At each rebasing, starting with 2013, each FQHC will submit their Medicaid cost report to the agency in a format and with content consistent with the agency instructions and the agreed upon procedures (AUP). The cost report is to be based upon financial information based on an A-133 audit and specified agreed upon procedures regarding Medicaid expenditure reporting to be completed by the independent auditor. Each FQHC's A-133 audit will include necessary review and an opinion on compliance with the AUP from an independent auditor.

- **Changes in Scope of Service** – For centers reimbursed under the APM, scope changes to add services are permitted. The State establishes an interim rate for any scope changes between rebasing periods. That interim rate is established through analysis on a prospective basis. Scope changes between rebasing periods related to intensity, duration, or amount of services are not allowed as rebasing corrects for these changes.

- **New FQHCs** – When a new FQHC enrolls in the Medicaid program, the first cost report period is the most current actual 12-month period coinciding with the facility's fiscal year end. Subsequent reporting periods will be based on the FQHC's fiscal year end and cost reports must be submitted no later than 120 days after the end of the FQHC's fiscal year.

- **Cost Reports -**

  - ✓ For **cost** reports received between the first and the 15th of the month, FQHC cost reimbursement is effective the first day of that month.

  - ✓ For cost **reports received after the 15th of the month**, the effective date of FQHC cost reimbursement is the first day of the subsequent month.

  - ✓ **A complete list of providers** for all programs during the cost report period must be included with the cost report. The list must state each provider's specialty and his/her license number and expiration date.

- **Overpayments -** If the State determines that an **FQHC received overpayments or payments in error**, the FQHC must refund such payments to the agency within 30 days after receipt of the final letter. A monthly repayment schedule for up to one year may be

requested. If this request is granted by the agency, an interest rate of 1% per month on the unpaid balance is assessed.

- **Underpayments -** If the agency determines that an **FQHC received underpayments**, the agency reimburses such payments within 30 days from the receipt of the letter.

Productivity, Full-Time Equivalent (FTE), and Treatment of On-Call Time

The State applies Washington-specific productivity standards for both physicians and mid-level practitioners (i.e., physician assistants, ARNPs, and CNMs). Minimum medical team productivity is calculated for services only in the medical/maternity cost center. Medical team FTEs are multiplied by the appropriate productivity standards and compared to each FQHC's encounters for those professionals. Psychiatrists are medical doctors and must meet FTE requirements if included in the medical/maternity cost center. The productivity standards apply in the manner in which they have been historically applied, and are only applied to practitioners who generate Medicaid encounters. The Washington-specific productivity standards are determined using the methodology outlined below.

To determine FTEs, the total number of hours paid (excluding payouts related to employee termination) for the year is divided by 2,080. FTEs for temporary, part-time, and contracted staff, including non paid physician time, are to be included on the cost report prior to any determination of whether or not they are permissible, which may remove them from the Washington Medicaid encounter rate.

On-call FTEs and encounters used for determining minimum productivity for medical and maternity services are based on the specific center agreement. These agreements must be documented. For the following types of on-call staff, the criteria for determining FTEs are:

- **Center staff who are assigned on-call as part of their normal duties and who receive no additional compensation for the on-call:** FTEs are calculated using the total hours paid. Total encounters are used in the minimum productivity calculation.

- **Center staff who are assigned to on-call as part of their normal duties and who receive additional compensation for on call:** FTEs are calculated using the hours paid at regular salary.

- **Contract staff who perform both regular and on-call duties:** FTEs are calculated using the hours paid for the regular duties. Only the encounters associated with the regular duties are used in the minimum productivity calculation.

Productivity Standards and Capped Overhead Methodology

The State of Washington applies productivity standards to the medical team costs and a cap to the administrative costs in the Capped Overhead cost category. The medical team includes physicians and mid-level practitioners (i.e., physician assistants, ARNPs, and CNMs). The productivity standards and administrative cap are set based on valid data submitted by Washington FQHCs and are considered valid by the State in a manner that ensures all reasonable costs are included.

The productivity standards and administrative cap are set at amounts greater than the average FQHC costs, but do not exceed a statistically determined amount (called the outlier cut-off). This ensures that only reasonable costs are included. The productivity standards and administrative cap are developed using data from the FQHCs' Medicaid cost reports.

Reasonable costs are defined as actual FQHC costs that do not exceed the average costs of similar FQHCs by more than a statistically determined amount (the outlier cut-off). Medical team costs and capped administrative expenses beyond the outlier cut-off are non reimbursable and are excluded from the cost reports.

Using the data, the State develops a statistical model reflecting the expected level for medical team costs and capped administrative expenses. The model then compares the costs and expenses of each FQHC to the expected levels. The model recognizes variables such as variations in population size and service scope, both of which affect medical costs and administrative expenses.

The outlier cut-off is the maximum value of a cost included in the cost report. Any costs above the cut-off are excluded. The cut-off is set at a certain number of standard deviations from the mean, depending on how the costs are distributed. If FQHC costs are more widely disbursed, the State sets the outlier cutoff at a higher absolute number than if costs are more tightly distributed. If the range of costs is more tightly distributed, the outlier cut-off is a lower number.

Under this model, there is no predetermined limit on allowable costs. If all FQHC costs fall within the expected range, they are all included. This ensures that all costs that are reasonable, and only those that are reasonable, are allowed.

Encounters for All Patients

Total (on-call and regular) staff expenses must be included on the cost report. The total encounters for all patients seen by staff (both regular and on-call) must be included on the cost report and used in calculating the encounter rate.

To verify the number of patients and associated number of encounters that physicians and mid-level practitioners have seen, the center must maintain records that substantiate the number of encounters for:

- Physicians and mid-levels practitioners who receive additional compensation for their on-call time; and

- Contract physicians and mid-levels during on-call time.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the agency's *ProviderOne Billing and Resource Guide*. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

How Do I Bill for Encounter Services?

Bill the agency an encounter using **only** the HCPCS code below:

Service Type	HCPCS Procedure Code	Fee-for-Service Procedure Code	Description	Billed Charges
Medical, dental, MSS, chemical dependency	T1015	Bill corresponding fee-for-service code of the underlying service being performed	All-inclusive center visit/encounter	Bill $0.00
Mental health (community mental health centers only)	T1015 with modifier HE	N/A	All-inclusive center visit/encounter	Bill $0.00.

Always list an encounter code on the same claim as its related fee-for-service procedure code(s). **Exception:** Mental health encounters can be billed with only the T1015 encounter code and modifier HE by FQHCs licensed as community mental health centers.

- When billing the encounter code, bill $0.00. For services eligible for encounter payments, the system will automatically pay the difference between the center's encounter rate and the FFS amount(s) paid.

- For clients in programs eligible for encounter payments, the agency denies Evaluation & Management codes when billed without a T1015.

> **Exception:** E&M CPT codes 99201 and 99211 can be billed without an encounter code for immunization services provided by registered nurses.

- When billing for services that do not qualify for encounter payments, do not use an encounter code on the claim form.

> **Note:** As client eligibility may change, bill encounter code T1015 on claims for *all* eligible services. ProviderOne will determine whether the encounter is payable when the claim is processed..

FQHC services provided to Agency clients must be billed to the agency on a paper CMS-1500 Claim Form or electronic 837P claim form. This includes claims with:

- An Explanation of Benefits (EOB) attachment from an insurance carrier; or
- A Medicare Explanation of Medicare Benefits (EOMB) denial.

> **Note:** For audit purposes, all encounters must have the specific procedure documented in the client's chart.

Multiple units may be billed with a single encounter code only in the following situations:

- Obstetrical care, which are billed as medical encounters;

- Dental care when a single service requires multiple visits (e.g., root canals, crowns, dentures); and

- Maternity support services, provided they are:

  - ✓ Different types of services,
  - ✓ Performed by different practitioners; and
  - ✓ Billed on separate claim forms.

How Do I Bill for More than One Encounter Per Day?

Encounters are limited to one per client, per day except in the following circumstances:

- The client needs to be seen by different practitioners with different specialties; **or**
- The client needs to be seen multiple times due to unrelated diagnoses.

Each encounter must be billed on a separate claim form. On each claim, to indicate that it is a separate encounter, enter "unrelated diagnosis" and the time of both visits in field 19 on the 1500 Claim Form or in the *Comments* field when billing electronically. Documentation for all encounters must be kept in the client's file.

What Procedure Codes Must a FQHC Use?

FQHCs *must* submit claims using the appropriate procedure codes listed in one of the following Medicaid provider guides, as applicable:

- Chemical Dependency Medicaid Provider Guide
- Dental-Related Services Medicaid Provider Guide
- Maternity Support Services/Infant Case Management Medicaid Provider Guide
- Orthodontic Services Medicaid Provider Guide
- Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide
- Prescription Drug Program Medicaid Provider Guide
- Other applicable program-specific Medicaid provider guides.

Claims must be submitted on the appropriate claim form:

- Medical services, maternity support services, infant case management, chemical dependency, and mental health on the CMS-1500 Claim Form.
- Dental services on the 2006 ADA Dental Form.
- Pharmacy claims through the Point-of-Sale (POS) system or on the Pharmacy Statement Claim Form, HCA 13-714.

How Do I Bill Taxonomy Codes?

- When billing for services eligible for an encounter payment, the agency requires FQHCs to use billing taxonomy 261QF0400X at the claim level.

- A servicing taxonomy is also required:

- ✓ Community Mental Health Centers must bill servicing taxonomy 261QM0801X or 251S00000X when billing for voluntary community health services (T1015 HE).

- ✓ Psychologists and psychiatrists billing for mental health encounters in combination with fee-for-service (FFS) codes must bill servicing taxonomy appropriate for the service being performed by the performing/rendering provider.

- ✓ Dental providers must bill the servicing taxonomy appropriate for the service being performed and the provider performing the service.

- ✓ Maternity support services/Infant case management provides must bill servicing taxonomy 171M00000X. Child birth education providers must bill servicing taxonomy 174400000X.

- ✓ Outpatient chemical dependency treatment providers must bill one of the following servicing taxonomies according to the service(s) provided:

  - ➢ 261QM2800X (for Opiate Substitution Services);
  - ➢ 251B00000X (for Case Management Services);
  - ➢ 324500000X (for Acute/Sub-Acute Detox services and Room and Board); or
  - ➢ 261QR0405X (for remaining published services).

- ✓ Medical and maternity services require a servicing taxonomy appropriate for the service being billed by the performing/rendering provider.

  - ➢ Family Planning Clinics must bill servicing taxonomy 261QA0005X.
  - ➢ Health departments must bill servicing taxonomy 251K00000X.

- If the client or the service does not qualify for an FQHC encounter, you may bill regularly as a non-FQHC without T1015 on the claim.

Billing Taxonomy Electronically

When billing electronically:

- Billing taxonomy goes in the 2000A loop.
- Rendering taxonomy goes in the 2310B loop.
- If the rendering provider is different than that in loop 2310B, enter taxonomy in the 2420A loop.

For more information on billing taxonomy, refer to the Health Insurance Portability and Accountability Act page

How Are the Claim Forms Completed?

Completing the CMS-1500 Claim Form

Note: Refer to the agency's *ProviderOne Billing and Resource Guide* for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to FQHCs:

Field No.	Name	Entry
24B	Place of Service	These are the only appropriate code(s) for this billing instruction: **Code** — **To Be Used For** 21 Inpatient hospital 22 Outpatient hospital 11 Office or ambulatory surgery center 12 Client's residence 23 Emergency room 31, 32 Nursing home 50 Federally Qualified Health Center 53 Community Mental Health Center 57 Non-residential Substance Abuse Treatment Facility 99 Other
24J	Rendering Provider ID#	Enter the service-specific taxonomy code (upper field) NPI (lower field)
33B	Physician's Supplier's Billing Name, Address, Zip Code and Phone #	Enter your billing NPI and FQHC taxonomy code 261QF0400X

Completing the UB-04 Claim Form

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: http://www.nubc.org/index.html.

Completing the 2006 ADA Claim Form

Note: Refer to the agency's *ProviderOne Billing and Resource Guide* for instructions on completing the 2006 ADA Claim Form.