Washington State Health Care Authority

Washington Apple Health (Medicaid)

Federally-Qualified Health Centers (FQHC) Billing Guide

July 1, 2020

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect July 1, 2020, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, call 1-800-562-3022. People who have hearing or speech disabilities call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Who should use this billing guide?

Federally qualified health centers (FQHCs) rendering services for encounter eligible Apple Health clients who are fee-for-service and not in an integrated managed care (IMC) plan.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Entire guide	General housekeeping, including hyperlink and typographical corrections	To improve usability
Determining whether a service is an encounter	Added procedure code 0202U under #7, 3rd bullet – list of underlying codes	New Propriety Laboratory Analyses (PLA) code for COVID-19

COVID-19 BILLING

See the Health Care Authority's Information about novel coronavirus (COVID-19) webpage for updated information regarding COVID-19.

COVID-19 clinical policy and billing instructions, including FQHC specific instructions and encounter eligible CPT codes, can be found in the agency's Apple Health (Medicaid) clinical policy and billing for COVID-19, Frequently Asked Questions.

Refer to the "What are the rules for telemedicine?" section of this guide for FQHC-specific telemedicine policy and billing instructions.

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

To access provider documents, go to the agency's provider billing guides and fee schedules webpage.

How can I get agency fee schedules?

To download and print agency fee schedules, go to the agency's Rates Development Fee Schedules webpage.

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Resources Available

Topic	Contact
Information on becoming a provider or submitting a change of address or ownership	See the agency's Billers and Providers webpage.
Information about payments, claims processing, denials, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing guides, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Submit claim denials for review	Follow the instructions in the agency's Billers and Providers webpage.
Information about ICD-10	Email: ICD10questions@hca.wa.gov
Who do I contact if I have questions about enrolling as a medical assistance-certified FQHC?	Provider Enrollment PO Box 45562 Olympia, WA 98504-5562 Ph.: 800-562-3022, ext. 16137 Fax: 360-725-2144 providerenrollment@hca.wa.gov
Who do I contact if I have a question about overall management of the program or specific payment rates?	Email: FQHCRHC@hca.wa.gov

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Alternative payment methodology (APM) index – 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. The APM index is used to update the APM encounter payment rates on an annual basis.

Base year – The year used as the benchmark in measuring an FQHC's total reasonable costs for establishing base encounter rates.

Behavioral Health Administrative Service Organization (BH-ASO) – Means an entity selected by the agency to administer behavioral health services and programs, including crisis services for all people in an integrated managed care regional service area. The BH-ASO administers crisis services for all people in its defined regional service area, regardless of a person's ability to pay.

Behavioral Health Services Only (BHSO) – Means the program in which enrollees receive only behavioral health benefits through a managed care delivery system.

Cost report – A statement of costs and provider usage 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 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. To ensure that the appropriate amounts are paid to each FQHC, the agency performs an annual reconciliation of the enhancement payments.

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.

Integrated Managed Care – Means the program under which a managed care organization provides:

- Physical health services funded by Medicaid; and
- Behavioral health services funded by Medicaid and other available resources provided for in chapters 182-538B, 182-538C, and 182-538D WAC.

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.

Medicaid certification date – The date an FQHC can begin providing services to Medicaid clients.

Mid-level practitioner –An advanced registered nurse practitioner (ARNP), a certified nurse midwife, a licensed midwife, a woman's health care nurse practitioner, a physician's assistant (PA), or a psychiatric ARNP. Services provided by registered nurses are not encounters.

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

Program Overview

What is a federally qualified health center (FQHC)?

A federally qualified health center (FQHC) is a facility that is any* of the following:

- 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 the grants referenced above based on the recommendation of the Health Resources and Services Administration (HRSA) within the Public Health Service, as determined by the secretary, to meet the requirements for receiving such a grant

- A Tribe or Tribal organization operating outpatient health programs or facilities under the Indian Self-Determination Act that elects to be designated as an FQHC (see the program overview in the *Tribal Health Program Billing Guide* for more information.)

**Refer to other requirements within this guide.*

An FQHC is unique only in the way 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 FQHC program is voluntary.

The agency allows only Department of Health and Human Services (DHHS)-designated FQHCs to participate in the 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 FQHC program?

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

What are the 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 Physician-Related Services/Healthcare Professional Services Billing Guide and other Washington Apple Health program-specific billing guides. 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. FQHC 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
  - ✓ 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
  - ✓ Serums and toxoids

Who may provide services in an FQHC?

(WAC 182-548-1300(3) and RCW 18.36A.040)

The following people may provide FQHC services:

- Physicians
- Dentists
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Nurse midwives or other specialized nurse practitioners
- Certified nurse midwives
- Registered nurses (RNs) or licensed practical nurses (LPNs)
- Mental health professionals – for a list of qualified professionals eligible to provide mental health services, refer to the Mental Health Services Billing Guide
- Naturopathic physicians, refer to the Physician-Related Services/Health Care Professional Services Billing Guide

Note: Providers approved to deliver screening, brief intervention, and referral to treatment (SBIRT) services, Maternity Support Services/Infant Case Management (MSS/ICM), and substance use disorder (SUD) services may also provide services in an FQHC.

What are the FQHC staffing requirements?

(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's 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 FQHC operates.
- The staff must be sufficient to provide the services essential to the operation of the FQHC.

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

How does an FQHC enroll as a provider?

(WAC 182-548-1200 (2))

To enroll as a provider and receive payment for services, an FQHC must:

- Receive FQHC certification for participation in the Title XVIII (Medicare) program according to 42 C.F.R. Part 491. Go to http://www.cms.hhs.gov/home/medicare.asp for information on Medicare provider enrollment.
- Submit a signed Core Provider Agreement (CPA).
- Comply with applicable federal, state, and local laws, rules, regulations, and agreements.

When enrolling a new clinic through ProviderOne, select the *Fac/Agency/Org/Inst* option from the enrollment type menu.

When adding a new site or service, indicate on the CPA that the provider is 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 60 calendar days** from the date of Medicare's letter notifying the center of the Medicare certification.

- **The date the agency receives the CPA:** The agency uses the date the signed CPA is received if the FQHC returns the properly completed CPA and FQHC enrollment packet **61 or more calendar days** after the date of Medicare's letter notifying the center of the Medicare certification.

Note: The FQHC enrollment packet includes: CPA, ownership disclosure form, debarment form, Electronic Funds Transfer (EFT) form, W9, copy of business license, copy of liability insurance information, and either the Centers for Medicare and Medicaid Services (CMS) approval letter or the Health Resources and Services Administration (HRSA) approval letter. Dental, Substance Use Disorder, and Maternity Support Services sites must provide the HRSA approval letter to the agency.

Servicing site location certification

All servicing sites listed under a clinic's domain within ProviderOne must be certified by either CMS or HRSA depending on the kinds of services offered at the location. Site certification documents can be faxed to the agency using the correct cover sheet, which will then be automatically attached to the domain requesting a new servicing location.

Refer to the agency's Billers and Providers website for document submission cover sheets. The correct cover sheet is the *Provider Information Update Requests* document. Because this is an established domain, select either the NPI or the ProviderOne ID option. The clinic's ProviderOne ID is the same number as the domain number. On the site approval document, note which location code this approval document pertains to.

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care webpage for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has 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 Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

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

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not 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 enrolled in an agency-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

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

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Note: To prevent billing denials, 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 agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina, and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:
  Go to Washington HealthPlanFinder website.

- **Available to all Apple Health clients:**

  ✓ Visit the ProviderOne Client Portal website:

  ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

  ✓ Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care; or
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS]).

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
"**Coordinated Care Healthy Options Foster Care.**"

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

Encounters

What is an encounter?

An encounter is a face-to-face visit between a client and an FQHC provider exercising independent judgment when providing health care services to the client. 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.
- The client needs to be seen multiple times on the same day due to unrelated diagnoses.

What services are considered encounters?

(WAC 182-548-1300)

Only certain services provided in the FQHC are considered encounters.

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 services qualify for FQHC reimbursement:

- Physician services specified in 42 CFR 405.2414
- Dental services specified in 42 CFR 440.100
- Nurse practitioner or physician assistant services specified in 42 CFR 405.2414
- Mental health services specified in the Mental Health Services Billing Guide
- 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
- Naturopathic physician services as specified in the Physician-Related Services Billing Guide

Services provided by other provider types (Maternity Support Services, substance use disorder, and mental health) may qualify as an encounter. Refer to specific sections within this guide for additional information.

Alcohol or substance misuse counseling

The agency covers alcohol or substance misuse counseling through screening, brief intervention, and referral to treatment (SBIRT) services. SBIRT services are encounter-eligible and may be billed in a variety of clinical contexts. See the Physician-Related Services/ Health Care Professional Services Billing Guide for additional information.

Surgical procedures

Effective August 31, 2014, and retroactive to dates of service on or after January 1, 2014, surgical procedures furnished in an FQHC by an FQHC practitioner are considered FQHC services, and the FQHC is paid based on its encounter rate for the face-to-face encounter associated with the surgical procedure.

Global billing requirements do not apply to FQHCs; however, surgical procedures furnished at locations other than FQHCs may be subject to global billing requirements.

If an FQHC provides services to a patient who has had surgery elsewhere while still in the global billing period, the FQHC must determine if these services have been included in the surgical global billing. FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service provided by the FQHC was included in the global payment for the surgery, the FQHC may not also bill for the same service.

For services not included in the global surgical package, see the Physician-Related Services/ Health Care Professional Services Billing Guide.

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 an 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 FQHC employees under the direct, personal supervision of encounter-level practitioners.
- Furnished by a member of the FQHC's staff who is an employee of the FQHC (e.g., nurse, therapist, technician, or other aide).

Incidental services and supplies described in this section that are included on the FQHC'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 contact with a client meets the Medicaid fee-for-service 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 registered nurses. These services must be billed as fee-for-service 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 either of the following circumstances:

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

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.

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

   Services in the FQHC
   Services performed in the FQHC (excluding those listed in 7, below) are encounters and are payable only to the FQHC.

   Services outside the FQHC
   A service that is considered an encounter when performed **in** the FQHC is considered an encounter when performed **outside** the FQHC (e.g., in a nursing facility or in the client's home) and is payable to the FQHC. A service not considered an encounter when performed **inside** the FQHC is also not considered an encounter when performed **outside** the FQHC, 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 claims.**

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

   - The claim is billed on a professional electronic claim or dental electronic claim.

   - One line-item procedure code equals T1015. See How do I bill for encounter services?

   - 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 The code of the underlying service must **not** be one of the following:

     ✓ 0202U
     ✓ 36400-36425
     ✓ 36511-36515
     ✓ 38204-38215
     ✓ 70000-79999
     ✓ 80000-89999
     ✓ 90281-90749
     ✓ A0021-A9999

- ✓ B4034-B9999
- ✓ D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0460, D0501, D1206, D1208, D1351, D1354, D1999*, D9995, D9996, and 99188
- ✓ E0100-E8002
- ✓ G0008-G9140 (with the exception of G0101)
- ✓ G9143-G9472
- ✓ All J codes
- ✓ K0001-K0902
- ✓ L0112-L9900
- ✓ P3000-P3001
- ✓ All Q codes
- ✓ All S codes - except S9482, S9436, and S9445-S9470 (inclusive)
- ✓ T1041
- ✓ U0001 and U0002

* Separately reimbursable during the COVID-19 pandemic.

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:

- FQHC clients identified in ProviderOne with one of the following medical coverage group codes and associated recipient aid category (RAC) codes do **not** qualify for the encounter rate effective for dates of service on and after January 1, 2014:

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), 1272
S95	RACs 1125, 1127
S99	RACs 1125, 1127
W01	All RACs (1128, 1129, 1170, 1171)

Medical Coverage Group Codes	RAC Code
W02	All RACs (1130, 1131, 1172, 1173)
W03	RAC 1132 (This is the only RAC for W03)
N31	RAC 1211 (replaces 1138 and 1139)
N33	RAC 1212, 1213 (replaces 1141, 1142)
A01	RAC 1214 (replaces 1041)
A01	RAC 1215 (replaces 1137)
A05	RAC 1216 (replaces 1145)

- Clients identified in ProviderOne with one of the following barcode (state-only) RAC codes for incapacity determination services do **not** qualify for the encounter rate effective for dates of service on and after September 1, 2015:

Barcode RAC
2000
2001
2002
2003
2004

- 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. **However**, **there is an exception for all health care services (including MSS) for RAC 1209 clients, which are not eligible for encounter payments during the 60-day postpartum period from the date of delivery.**

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.)
N23	RAC 1209 (Replaces RAC 1096)
P04	RAC 1096 (This is the only RAC for P04.)
P99	RAC 1102 (This is the only RAC for P99.)

What services do not qualify as encounters?

The following are examples of services that are not encounter-eligible but are reimbursed fee-for-service:

- Blood draws, laboratory tests, x-rays, and prescriptions. However, these procedures may be provided in addition to other medical services as part of an encounter.
- The administration of drugs and biologicals, including pneumococcal, influenza, and other immunizations.
- Delivery and postpartum services provided to pregnant undocumented alien client. Global care must be unbundled. The agency does not pay for an encounter for the delivery, postpartum care, or any health care services (including MSS) during the 60-day postpartum period, including the date of delivery.
- 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. Exception: Do not bill T1015 for RAC 1209 for services performed during the 60-day postpartum period,

- **Effective for claims with dates of service on and after July 1, 2016,** services performed in an inpatient hospital setting are not encounter-eligible. Covered services will be paid as fee-for-service and must not be billed with encounter code T1015. Refer to "How do I bill for maternity care?" for billing for hospital-based maternity care.

Collaborative care model (CoCM) services

Collaborative care is a specific type of integrated care that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature. These services may be performed in the FQHC setting by qualified medical professionals but are not encounter-eligible and must be billed on a fee-for-service basis using procedure code G0512. Additional COCM registry and billing information is located in the Physician-Related Services/ Health Care Professional Services Billing Guide.

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 permitted cost centers. Those cost centers are:

- Medical/maternity – lower acuity mental health services
- Maternity Support Services/Infant Case Management
- Dental
- Mental health – higher acuity services
- Substance use disorder
- Mental health – Psychiatrist/psychologist for lower acuity mental health services

Medical/maternity/mental health encounter

A medical/maternity/mental health encounter is a face-to-face encounter between an approved provider and a client during which services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury, or for prenatal care or delivery.

Services provided by approved professionals are considered eligible for an encounter payment as long as the billing code falls outside the range of ineligible codes outlined on page~~s~~ 27 of this guide. Specific policy regarding billing for medical/maternity/mental health services can be found in the appropriate Washington Apple Health program-specific billing guide.

An encounter code and any related fee-for-service code must be billed on the same claim.

Maternity Support Services and Infant Case Management (MSS/ICM)

For an FQHC to submit encounters and include costs for MSS/ICM in cost reports, the FQHC 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/Infant Case Management Billing Guide.

> **Note:** When billing more than one unit for MSS/ICM services, bill units as defined by each specific code in the Maternity Support Services/Infant Case Management Billing Guide.

An MSS/ICM encounter is a face-to-face encounter between an MSS/ICM provider and a client during which MSS/ICM services are provided.

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

Members of the MSS/ICM interdisciplinary team 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/Infant Case Management Billing 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 (MSS) encounter, per day, per client, if they are:

- Different types of services
- Performed by different practitioners with different specialties
- Billed on separate claim forms

> **Note:** When billing for more than one MSS encounter for the same date of service and client, use modifier XP with the procedure code T1015 on the second claim.

Dental encounter

For an FQHC to submit encounters and include costs for dental care in cost reports, the FQHC must be approved by the agency and must meet the billing and eligibility requirements as specified in the Dental-Related Services Billing Guide and the Orthodontic Services Billing Guide.

A dental encounter is a face-to-face encounter between a dentist, dental hygienist, or orthodontist 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 providing 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.

When fluoride treatment and sealants are provided on the same day as an encounter-eligible service, they must be billed on the same claim. If they are not provided on the same day with an encounter-eligible service, they may be billed for fee-for-service reimbursement.

Mental health encounter – clients whose mental illness requires a higher acuity service

To provide mental health services that qualify under this separate cost center, the FQHC must be a licensed community mental health center and have a contract with a BHSO, or BH-ASO for Medicaid clients only. Included in this category are mental health professionals, as defined by RCW 71.34.020.

Mental health encounter – psychiatrists and psychologists

Services provided by psychiatrists and psychologists are considered eligible for an encounter payment as long as the billing code falls outside the range of eligible codes outlined in this guide. Specific policy regarding billing for mental health services is found in the Mental Health Services Billing Guide.

Substance use disorder treatment programs

An FQHC treatment facility must be approved by the agency under applicable WACs and RCW 71.24.

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 Apple Health program. Refer to WAC 182-501-0060 Health care coverage - Program benefits packages - Scope of service categories.
- Medically necessary as defined in WAC 182-500-0070.

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 Apple Health bases FQHC reimbursement on Washington's CMS-approved Title XIX Medicaid State Plan. CMS only permits reimbursement based upon reasonable costs for services defined in the State Plan, or as defined in Section 1861 (aa) of the Social Security Act, which lists FQHC-required core services. Reimbursement is not permitted for services not in the 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 outlined in the Benefits Improvement and Protection Act of 2000 (BIPA) statutory language or under an alternative payment methodology (APM).

- For information on how the agency calculates the prospective payment system 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 FQHCs for services eligible for an encounter on an **encounter rate** basis rather than a fee-for-service (FFS) basis.

All FQHC services and supplies incidental to the provider's services are included in the encounter rate payment (WAC 182-548-1450 (2)).

The agency limits encounters to one per client, per day, except in the following circumstances (WAC 182-548-1450 (1)):

- The visits occur with different health care professionals with different specialties.
- There are separate visits with unrelated diagnoses.

> **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 for encounters by calculating the difference between the encounter rate and the amount reimbursed to the FQHC based on the FFS method. For instance:

Example one:	$150.00	Medical Encounter Rate
	× 1	# of Medical Encounters for Claim
	$150.00	**Total Amount Due**
	$150.00	
	-$75.00	Fee-for-Service Paid
	$75.00	**Encounter Amount Paid**
Example two:	$150.00	
	-$200.00	Fee-for-Service Paid
	- $50.00	**Negative Encounter Amount**

Payment for services not eligible for an encounter

(WAC 182-548-1450(4))

Payments for non-FQHC services provided in an FQHC are made on a FFS basis using the agency's fee schedules. **For information on FFS reimbursement,** refer to the appropriate Fee Schedules.

Choice of rates

FQHCs may choose to have:

- An all-inclusive rate, which covers all encounter services
- Individual rates for each of the permitted cost centers
- A grandfathered rate structure consistent with the rate structure used for prospective payment system 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. The cost centers are:

- Medical/maternity/lower acuity mental health services
- Maternity Support Services/Infant Case Management
- Dental
- Mental health – higher acuity services
- Substance use disorder
- Mental health – psychiatrist/psychologist for lower acuity mental health services

Managed care clients

(WAC 182-548-1450(7))

For clients enrolled with a managed care organization (MCO), covered FQHC services are paid by the MCO. Only services provided to clients enrolled in Title XIX (Medicaid) or Title XXI (CHIP) programs are eligible for encounter payments. Neither the agency nor the MCO pays the encounter rate for services provided to clients in state-only medical programs. Services provided to clients in state-only medical programs are considered FFS 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 an FQHC's encounter rate. The payments are generated from client rosters submitted to the agency by the MCOs. The agency sends the monthly enhancement payments to MCOs to be distributed to the FQHCs. FQHCs receive payment for monthly rosters two months after the roster is submitted to HCA by an MCO. For example, accepted rosters submitted by an MCO to HCA in the month of January will be paid to the MCOs in February and the MCO will pay the FQHC in March.

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. If the FQHC was overpaid, the agency will recoup the appropriate amount. If the FQHC was underpaid, the agency will pay the difference. It is the FQHC's responsibility to perform internal monthly verifications to ensure that they have received all their payments.

Due to the integration of managed care, FQHC qualified behavioral health (high acuity mental health and SUD) encounters for managed care clients will now be included in the annual reconciliation in addition to medical encounters. FQHCs will receive enhancement payments to ensure appropriate amounts are paid to each FQHC for high acuity mental health services.

Based on the results of the reconciliation, the agency may adjust the enhancement rate to avoid significant overpayments or underpayments and to lessen the financial impact to the agency and the FQHC. In addition, the FQHC can request enhancement rate changes, which depend on agency final approval.

Note: HCA uses client rosters to determine total annual enhancement payments as part of the reconciliation process. MCOs and FQHCs are responsible for ensuring all client roster adjustments, including retroactive roster adjustments, are submitted to HCA by no later than June 15th in the year following the year of the roster assignment. HCA will not accept client assignments for the previous year after the annual deadline.

Example: All client rosters for year 2018, including retro adjustments, must be submitted to HCA on or before June 15, 2019.

Are FQHCs liable for payments received?

Each FQHC is responsible for submitting claims for services provided to eligible clients. The claims must be submitted under the rules and billing instructions in effect at the time the service is provided.

Each FQHC is individually liable for any payments received, and must ensure that these payments are for only those situations described in this and other Washington Apple Health program-specific billing guides, and federal and state rules. FQHC claims are subject to audit by the agency, and FQHCs are responsible to repay any overpayments.

Upon request, FQHCs must give the agency complete and legible documentation that clearly verifies any services for which the FQHC has received payment.

How does the agency prevent duplicative payment for pharmacy and behavioral health services?

The agency performs monthly recoupments for fee-for-service pharmacy services delivered by FQHCs in order to avoid duplicate payments for pharmacy services already included in their encounter rate.

For FQHCs with BHSO and BH-ASO contracts, the agency conducts monthly recoupments based on the contracted amount, or the amount the FQHC is paid by the BHSO and BH-ASO for clients assigned to an FQHC. The recoupments are performed for clients receiving behavioral health services through the Medicaid fee-for-service program (billed directly through ProviderOne).

The agency works with FQHCs to conduct a reconciliation of the past period to ensure that clinics were reimbursed appropriately.

To avoid the monthly pharmacy recoupment process, ingredient costs and dispensing fees (for all payers) may be removed from the Medicaid cost report if the FQHC has a qualifying event as outlined in the change in scope section below. Removal of pharmacy from the cost report alone does not constitute a change in scope of services.

What is a change in scope of service?

[WAC 182-548-1500 and 42 U.S.C. 1396a(bb)(3)(B)]

A change in scope of service occurs when the type, intensity (the total quantity of labor and materials consumed by an individual client during an average encounter), duration (the length of an average encounter), or amount of services provided by the FQHC changes. When such changes meet the criteria described below, the FQHC may qualify for a change in scope of service rate adjustment.

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

What are the criteria for a change in scope of service rate adjustment?

The agency may authorize a change in scope of service rate adjustment when the following criteria are met:

- The change in the services provided by the FQHC meet the definition of FQHC services as defined in section 1905(a)(2)(C) of the Social Security Act.
- Changes to the type, intensity, duration, or amount of services have resulted in an increase or decrease in the FQHC's cost of providing covered health care services to eligible clients. The cost change must equal or exceed any of the following:

  - ✓ An increase of 1.75 percent in the rate per encounter over one year
  - ✓ A decrease of 2.5 percent in the rate per encounter over one year
  - ✓ A cumulative increase or decrease of 5 percent in the cost per encounter as compared to the current year's cost per encounter

- The costs reported to the agency to support the proposed change in scope rate adjustment are reasonable under applicable state and federal law.

How is a change in scope of service rate adjustment requested?

A change in scope of service rate adjustment may be requested by the agency or by an FQHC.

When may the agency request an application for a change in scope of service rate adjustment?

At any time, the agency may require an FQHC to file an application for a change in scope of service rate adjustment. The application must include a cost report, "position statement," which is an assertion as to whether the FQHC's prospective payment system rate should be increased or decreased due to a change in the scope of service, and other application requirements follow:

- The FQHC must file a completed cost report and position statement no later than 90 calendar days after receiving the agency's request for an application.
- The agency reviews the FQHC's cost report, position statement, and application for change in scope of service rate adjustment using the criteria listed under *What are the criteria for a change in scope of service rate adjustment?*
- The agency will not request more than one change in scope of service rate adjustment application from an FQHC in a calendar year.

When may an FQHC request an application for a change in scope of service rate adjustment?

Unless the agency instructs the FQHC to file an application for a change in scope of service rate adjustment, an FQHC may file only one application per calendar year. However, more than one type of change in scope of service may be included in a single application.

An FQHC may apply for a prospective change in scope of service rate adjustment, a retrospective change in scope of service rate adjustment, or both.

An FQHC must file an application for a change in scope of service rate adjustment no later than 90 days after the end of the calendar year in which the FQHC believes the change in scope of service occurred or in which the FQHC learned the cost threshold was met, whichever is later.

What is a prospective change in scope of service?

A prospective change in scope of service is a change the FQHC plans to implement in the future. To file an application for a prospective change in scope of service rate adjustment, the FQHC must submit projected costs sufficient to establish an interim rate. If the application for a prospective change in scope of services rate adjustment is approved by the agency, an interim rate adjustment will go into effect after the change takes effect.

The interim rate is subject to a post-change in scope review and rate adjustment.

If the change in scope of service occurs fewer than 90 days after the FQHC submits a complete application to the agency, an interim rate takes effect no later than 90 days after the FQHC submits the application to the agency.

If the change in scope of service occurs more than 90 days but fewer than 180 days after the FQHC submits a complete application to the agency, the interim rate takes effect when the change in scope of service occurs.

If the FQHC fails to implement a change in service identified in its application for a prospective change in scope of service rate adjustment within 180 days, the application is void. The FQHC may resubmit the application to the agency. The agency does not consider the resubmission of a voided application as an additional application.

Supporting documentation for a prospective change in scope of service rate adjustment

To apply for a change in a prospective scope of service rate adjustment, the FQHC must include the following documentation in the application:

- A narrative description of the proposed change in scope of service that explains how each proposed change meets the requirements for change in scope of amount, duration, intensity, or type.
- A description of each cost center on the cost report that will be affected by the change in scope of service
- The FQHC's most recent audited financial statements for the same time period as the cost reports, if an audit is required by federal law

- The implementation date for the proposed change in scope of service
- The projected Medicaid cost report (in electronic Excel format), with the supplemental schedules needed to identify the Medicaid cost per visit for the 12-month period following the implementation of the change in scope of service
- Any additional documentation requested by the agency

What is a retrospective change in scope of service?

A retrospective change in scope of service occurs when a change took place in the past and the FQHC is seeking to adjust its rate based on that change.

For example, if the FQHC submits a completed application on September 1, 2017, the agency begins the review process and sets the final rate within 90 days. This rate is effective on September 1, 2017, the date the agency received the completed application.

An application for a retrospective change in scope of service rate adjustment must state each qualifying event that supports the application and include 12 months of data documenting the cost change caused by the qualifying event. If approved, a retrospective rate adjustment takes effect on the date the FQHC filed the complete application with the agency.

Supporting documentation for a retrospective change in scope of service rate adjustment

To apply for a retrospective change in scope of service rate adjustment, the FQHC must include the following documentation in the application:

- A narrative description of the proposed change in scope of service that explains how each proposed change meets the requirements for a change in amount, duration, intensity, or type
- A description of each cost center on the cost report that was affected by the change in scope of service
- The FQHC's most recent audited financial statements for the same time period as the cost reports, if an audit is required by federal law
- The implementation date for the proposed change in scope of service
- The Medicaid cost report (in electronic Excel format), with the supplemental schedules necessary to identify the Medicaid cost per visit and the encounter data for the 12 months or the fiscal year following implementation of the proposed change in scope of service
- The Medicare cost report*
- An attestation statement confirming all encounters/visits are included in the Medicaid cost report
- Any additional documentation requested by the agency

How does the agency process applications for a change in scope of service rate adjustment?

The agency reviews an application for a change in scope of service rate adjustment for completeness, accuracy, and compliance with program rules.

Within 60 days of receiving the application, the agency notifies the FQHC of any deficient documentation or requests any additional information that is necessary to process the application.

Within 90 days of receiving a complete application, the agency sends the FQHC:

- A decision stating whether (approval or denial) it will implement a prospective payment system rate change
- A rate-setting statement

If no action is taken within 90 days, the request is considered denied by the agency and the FQHC may appeal the decision.

How does the agency set an interim rate for prospective changes in the scope of service?

The agency sets an interim rate for prospective changes in the scope of service by adjusting the FQHC's existing rate by the projected average cost per encounter of any approved change.

The agency reviews the projected costs to determine if they are reasonable, and sets a new interim rate based on the determined cost per encounter.

How does the agency set an adjusted encounter rate for retrospective changes in the scope of service?

The agency sets an adjusted encounter rate for retrospective changes in the scope of service by changing the FQHC's existing rate by the documented average cost per encounter of the approved change.

Projected costs per encounter may be used if there is insufficient historical data to establish the rate. The agency reviews the costs to determine if they are reasonable, and sets a new rate based on the determined cost per encounter.

If the FQHC is paid under an alternative payment methodology (APM), any change in the scope of service rate adjustment requested by the FQHC will modify the prospective payment system (PPS) rate in addition to the APM.

The agency may delegate the duties related to application processing and rate setting to a third party. The agency retains final authority for making decisions related to changes in scope of service.

When does the agency conduct a post change in scope of service rate adjustment review?

The agency conducts a post change in scope of service review within 90 days of receiving the cost report and encounter data from the FQHC. If necessary, the agency will adjust the encounter rate within 90 days of the review to ensure that the rate reflects the reasonable cost of the change in scope of services.

A rate adjustment based on a post change in scope of service review will take effect on the date the agency issues its adjustment. The new rate will be prospective.

For example, if the FQHC submits a completed application on September 1, 2017, the agency begins the review process and sets the final rate within 90 days. For a review that concludes on December 1, 2017, the FQHC's new rate is effective on December 1, 2017. If the same review concludes on November 1, 2017, the new rate for the FQHC is effective November 1, 2017.

If the application for a change in scope of service rate adjustment was based on a year or more of actual encounter data, the agency **may** conduct a post change in scope of service rate adjustment review.

If the application for a change in scope of service rate adjustment was based on less than a full year of actual encounter data, the FQHC **must** submit the following information to the agency within 18 months of the effective date of the rate adjustment:

- A Medicaid cost report (in electronic Excel format), with the supplemental schedules necessary to identify the Medicaid cost per visit
- Medicare cost report
- Encounter data for 12 consecutive months of experience following implementation of the change in scope
- The FQHC's most recent audited financial statements for the same time period as the cost reports, if an audit is required by federal law
- An attestation statement confirming all encounters are included in the Medicaid cost report
- Any additional documentation requested by the agency

If the FQHC fails to submit the post change in scope of service cost report or related encounter data, the agency provides written notice to the FQHC of the deficiency within 30 days.

If the FQHC fails to submit required documentation within five months of this deficiency notice, the agency may reinstate the encounter rate that was in effect before a change in the scope of service rate was granted. The rate will be effective the date the interim rate was established. Any overpayment to the FQHC may be recouped by the agency.

May an FQHC appeal an agency action?

Yes. Appeals are governed by WAC 182-502-0220, except that any rate change begins on the date the agency received the application for a change in scope of service rate adjustment.

What are examples of events that qualify for a rate adjustment due to changes in scope of service?

The following examples illustrate events that would qualify for a rate adjustment due to changes in the type, intensity, duration, or amount of service:

- Changes in the patients served, including populations with HIV/AIDS and other chronic diseases; patients who are homeless, elderly, migrant, limited in English proficiency; or other special populations
- Changes in the technology of the FQHC, including, but not limited to, electronic health records and electronic practice management systems
- Changes in the FQHC's medical, dental, or behavioral health practices, including, but not limited to, the implementation of patient-centered medical homes, opening for extended hours, or changes in prescribing patterns
- Capital expenditures associated with a modification of any of the services provided by the FQHC, including relocation, remodeling, opening a new site, or closing an existing site
- Changes in service delivery due to federal or state regulatory requirements

What are examples of events that do not qualify for a rate adjustment due to changes in scope of service?

The following examples illustrate events that would not qualify for a rate adjustment due changes in the type, intensity, duration, or amount of service:

- Addition or reduction of staff members not directly related to the change in scope of service
- An expansion or remodel of an existing FQHC that is not directly related to the change in scope of service
- Changes to salaries, benefits, or the cost of supplies not directly related to the change in scope of service
- Changes to administration, assets, or overhead expenses not directly related to the change in scope of service
- Capital expenditures for losses covered by insurance
- Changes in office hours, location, or space not directly related to the change in scope of service
- Changes in patient type and volume without changes in type, duration, or intensity of service
- Changes in equipment or supplies not directly related to the change in scope of service

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, Part 413
- Agency policies and definitions, including all Washington Apple Health billing guides
- Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR, Part 200)
- Medicare Provider Reimbursement Manual (MPRM)

Note: Professional medical services that are not normally provided to Medicare beneficiaries are not included on the FQHC's Medicare cost report and are not used for the calculation of the FQHC'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.

What are allowable costs?

Allowable costs are documented costs as reported after any cost adjustments, 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 health care costs?

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

[*] 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 costs 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.

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's or dentist's office, and ordinarily rendered without charge or included in the practice bill, such as ordinary medications, other services, and medical supplies used in patient primary care services. "Incident to" services must be furnished by an FQHC 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.

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 all behavioral health services, both lower and higher acuity, provided by psychologists in an appropriately licensed FQHC because they are core services.

The following services are covered, and costs for these services provided to Washington Apple Health 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 certified nurse-midwives) services – to the extent covered in Washington statute and administrative code, including costs for contracted mid-level practitioner services.

  - ✓ Clinical psychologist services – all levels of mental health services, to the extent covered in Washington statute and administrative code.

  - ✓ Licensed clinical social worker services (LCSWs) – all levels of mental health services, to the extent covered in Washington statute and administrative code.

  - ✓ 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 FQHC practitioners in outpatient, inpatient, emergency room, or swing bed facilities of a hospital (i.e., physicians' services for obstetrics) as covered in the Washington Medicaid 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 fee-for-service claim and instructions in the Washington Apple Health program-specific billing guides 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 FQHC. FQHCs should continue to claim pharmacy reimbursement under the fee-for-service pharmacy program. All pharmacy costs should be included in the medical/maternity cost center of the cost report, including PharmD prescribing).

- **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 providing lower acuity levels of service, to the extent covered in Washington statute and administrative code.

- **Diabetes self-management training services and medical nutrition therapy services** – to the extent covered in Washington statute and administrative code

- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.**

- **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 fee-for-service 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.

Costs for the services provided to Washington Apple Health beneficiaries may be included in the cost report.

What are unallowable direct health services costs?

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

- **Mental health services** provided outside of the BHSO or BH-ASO contract for people requiring higher acuity mental health services.

- **Women, Infants and Children (WIC) program** – the agency reimburses for nutritional assessments and nutritional counseling in the WIC program only when the service is part of the EPSDT program. Costs for nutritional assessment and 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 client assessment:** Pregnant clients 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** required to enhance job performance for employees of the FQHC, except for training and staff development. Student loan reimbursements are considered unallowable education expenses.

- **Beneficiary outreach and outreach to potential clients**, except for informing the target population of available services 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 people served or the number of services received by people accessing services.

- **Assisting other health care professionals** to provide 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. Examples include costs of meetings, conventions, convocations, or other events related to non-Medicaid activities of the non-profit organization, such as: 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; 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 toxic shellfish.

- **Research**

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

- **Costs for subcontracted services** (referred services) other than subcontracted physicians and mid-level practitioners. Examples include: 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 FQHC.**

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

- **Transportation costs** – Transportation costs are not included in the cost report and the trip does not result in a billed encounter.

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 percent 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 FQHC'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**.

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

- **Dues for personnel to professional organizations** that are directly related to the person'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 method 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 use its Medicare depreciation schedule for all items and maintain documentation of that schedule for Medicaid auditors
- **Dues to industry organizations –** These are limited to:
  - ✓ Dues that are not grant-funded or used by organizations for lobbying activities
  - ✓ **One industry organization per FQHC**

  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 FQHC administration purposes)
- **Finance and Audit Agency costs**
- **Human Resources Agency costs**
- **Administration and disaster recovery and preparedness costs**
- **Facility and phone costs** for out-stationed financial workers provided by Community Service Offices (CSO). Any revenues received from a CSO for facility and other costs must also be recorded as a fee-for-service 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
  - ✓ Consultants

What are unallowable overhead costs and other expenses?

Unallowable costs as noted in 42 CFR, Part 413 are unallowable in the Washington cost report. Additional unallowable overhead costs and other expenses include:

- **Costs not related to patient care**

- **Indirect costs allocated to unallowable direct health service costs** – These are also unallowable per 2 CFR 200.413(e). 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
  - ✓ 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
  - ✓ 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 FQHC (e.g., FQHC-sponsored annual meetings, retreats, and seminars). Allowable travel includes 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 2 CFR 200.434

- **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 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 Medicaid agency. This is in addition to the unallowable costs listed for similar costs in connection with any criminal, civil or administrative proceeding in 2 CFR 200.435.

- **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 2 CFR 200.450

- **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 providing 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 cost to the related organization or the price of comparable service. 2 CFR 200.451 addresses consulting directly related to services rendered.

- **Vending machine expenses**

- **Charitable contributions**

- **Personnel costs for out-stationed financial workers** provided by Community Service Offices (CSO). The CSO makes the final decision on whether or not to out-station CSO staff based on an evaluation of the level of Medicaid activity and resources available. When CSO staff are out-stationed 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 fee-for-service 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, Part 413, and in 2 CFR, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

What are the requirements for cost reports?

Complete the Washington Medicaid cost reports consistent with the Washington FQHC Cost Report Instructions. The cost report starts with the audit required under 42 CFR, Part 200 and has the following cost centers:

- Medical/maternity
- Maternity Support Services/Infant Case Management
- Dental
- Mental health
- Substance use disorder

Alternative payment methodology (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

- A grandfathered rate structure consistent with the rate structure used for prospective payment system 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 prospective payment system encounter rates (i.e., increasing the encounters in the APM calculation would cause the APM prospective payment system to deflate, allowing the FQHCs to claim the higher historic prospective payment system 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, Part 413
  - ✓ Agency policies and definitions
  - ✓ Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR, Part 200) Medicare Provider Reimbursement Manual

- **Documentation** – Documentation must be available for the auditors in the client's medical record at the FQHC. 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 most recent audited Medicare cost reports from the CMS-contracted firm that audits the cost reports.

- **Rebasing** – FQHCs reimbursed under the APM had the option to rebase their encounter rate in 2010. Each FQHC that chose to rebase in 2010 was required to submit the Medicaid FQHC cost report that corresponded with the fiscal year in the most recent trial balance audit under 2 CFR, Part 200 consistent with the Cost Report Instructions. The agency periodically rebases the FQHC encounter rates using the FQHC cost reports and other relevant data.

  At each rebasing, FQHCs submit their Medicaid cost report to the agency in a format and with content consistent with agency instructions and the agreed-upon procedures (AUPs). The cost report is to be based upon financial information from the most recent audit under 2 CFR, Part 200 and specified AUPs regarding Medicaid expenditure reporting to be completed by the independent auditor. Each FQHC's audit under 2 CFR, Part 200 will include necessary review and an opinion on compliance with the AUP from an independent auditor.

- **Changes in Scope of Service** – Refer to the Change in Scope of Service section of this billing guide for more information. Retrospective changes in scope of service requests are not allowed during the periodic rebase process as rebasing adjusts 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 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 certified nurse-midwives). 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 FQHC agreement. These agreements must be documented. For the following types of on-call staff, the criteria for determining FTEs are:

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

- **FQHC 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 certified nurse-midwives). The productivity standards and administrative cap are based on valid data submitted by 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 changes 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 the associated number of encounters that physicians and mid-level practitioners have seen, the FQHC must maintain records that substantiate the number of encounters for physicians and mid-levels practitioners who receive additional compensation for their on-call time, as well as contracted physicians and mid-level practitioners during on-call time.

Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- When providers may bill a client
- Services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record-keeping requirements

What special rules are there for FQHCs to follow when billing?

- All related services performed on the same day by the same clinician or by the same provider specialty must be billed on the same claim. This includes any services performed during an encounter-eligible visit that are not encounter-eligible. For example, lab services performed at the same visit as evaluation and management.

- An encounter-eligible service must be billed in combination with the T1015 procedure code.

Note: The FQHC must bill a TH modifier on the same line as T1015 to generate a multiple-unit encounter payment for global maternity services.

- If reprocessing a denied service or a service that was not correctly included when the original claim was billed, the paid claim must be adjusted. If the original claim is not adjusted to add these services, the additional claim may be denied.

- If a non-encounter-eligible service is billed and paid prior to an encounter-eligible claim submission for the same date of service, adjust the paid claim and submit the services together to receive payment.

How do I bill for encounter services?

Bill the agency an encounter using the HCPCS code below:

Service Type	HCPCS Procedure Code	Fee-for-Service (FFS) Procedure Code	Description	Billed Charges
Medical, dental, lower acuity mental health, MSS, substance use disorder*	T1015	Bill corresponding fee-for-service code of the underlying service being performed	All-inclusive FQHC visit/encounter	Bill $0.00
MSS (second claim on same day)	T1015 with modifier XP	Bill corresponding fee-for-service code of the underlying service being performed	All-inclusive FQHC visit/encounter	Bill $0.00
Mental health (community mental health centers only for higher acuity mental health services)*	T1015 with modifier HE	N/A	All-inclusive FQHC visit/encounter	Bill $0.00

* For clients enrolled in the integrated managed care program, bill the client's managed care organization (MCO) for contracted mental health and substance use disorder (SUD) services. Do not bill the agency for these clients. For clients who are receiving behavioral health services through the Medicaid fee-for-service program, bill the agency for these services through ProviderOne.

Note: Substance use disorder claims must be billed using the T1015 and the corresponding fee-for-service (FFS) code. In certain cases, the paid claim might show the encounter rate payment under the paid T1015 code and show denied for the FFS code. This is not an error, it is programmed this way to allow the ProviderOne system to pay the entire encounter rate on the claim.

- **Always** list an encounter code on the same claim as its related fee-for-service procedure code or codes.

> **Exception:** FQHCs licensed as community mental health centers by the Department of Health must bill higher acuity mental health encounters with only the T1015 encounter code and the modifier HE for clients receiving services through the Medicaid fee-for-service program

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

- To ensure correct payment for the T1015 encounter code, all third-party payment information must be reported at the header claim level only.

- For clients in programs eligible for encounter payments, the agency denies Evaluation and Management (E&M) 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. (See the What services do not qualify as encounters? section of this guide.)

> **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 professional electronic claim. This includes claims with:

- An Explanation of Benefits (EOB) attachment from an insurance carrier
- 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).

> **Note:** The agency will not reimburse for early (before 39 weeks of gestation) elective deliveries. See the Physician-Related Services/Health Care Professional Services Billing Guide for additional instructions.

How do I bill for maternity care?

The following maternity services are eligible for an encounter payment:

- Each prenatal and postpartum maternity care visit
- A delivery performed outside a hospital setting

A delivery performed in any hospital setting does not qualify as an encounter and must be billed as fee-for-service, using the appropriate delivery-only CPT code.

Any time unbundling is necessary, antepartum-only codes and postpartum-only codes must be billed in combination with encounter code T1015 for the same date of service.

When the client is seen on multiple days for a maternity package fee-for-service code, bill using encounter code T1015 with a TH modifier. The units on the encounter line must equal the number of days that the client was seen for encounter-eligible services related to the fee-for-service code. See the Physician-Related Services/Health Care Professional Services Billing Guide for additional instructions.

If the delivery is outside the hospital, the same is true regarding multiple encounter units. However, obstetrical fee-for-service global CPT codes must be used when all maternity services to the client are provided through the FQHC. When delivery is in the hospital, unbundle and bill the appropriate delivery-only fee-for-service code on a separate claim without an encounter.

How do I bill for orthodontic services performed in an FQHC?

When billing for orthodontic services, FQHCs are required to follow the same guidelines as non-FQHC providers. However, orthodontic codes that are considered "global" and therefore cover a specific length of time are billed at the end of the time indicated – except for the initial placement of the device, which is billed on the date of service. Because FQHCs are reimbursed by an encounter payment, they are allowed to bill up to the maximum number of encounters as shown in the chart below. The chart below illustrates comprehensive treatment timeframes and maximum units allowed during those periods.

	Comprehensive treatment (D8080)										Total encounters allowed
Months from Appliance Placement date	0	6 *	9	12	15	18	21	24	27	30	
Number of encounters allowed	0	5**	2	2	2	2	2	2	2	2	21

* The date of service on the claim is the same as the appliance placement date.
** FQHC records must document the five separate visits.

During the first six months of the appliance placement, an FQHC may bill on the date of the appliance placement for one unit and up to a total of five units. To bill for more than one unit during the first six months, the FQHC must see the client and document the encounter in the client's file. If an FQHC chooses to bill in this manner instead of waiting the full six months, the latest paid claim must be adjusted each time and another unit added to the line containing the T1015 code. If the claim is not adjusted, the claim will be denied as a duplicate billing.

The chart below is similar to the comprehensive treatment chart, but is for limited orthodontic treatment.

	Limited orthodontic treatment (D8030)					Total Encounters allowed
Months from appliance placement date	0	3*	6	9	12	
Number of encounters allowed	0	4**	2	2	2	10

* Use the appliance placement date for billing.
** Clinic records must document four separate visits.

An FQHC may bill on the date of the appliance placement for one unit and up to a total of four units during the first three months of the appliance placement. To bill for more than one unit during the first six months, the FQHC must see the client and document the encounter in the client's file. If a clinic choses to bill in this manner instead of waiting the full three months, the latest paid claim must be adjusted each time, and another unit added to the line containing the T1015 code. If the claim is not adjusted, the claim will be denied as a duplicate billing.

What are the rules for telemedicine?

FQHCs are authorized to serve as an originating site for telemedicine services. An originating site is the location of a client at the time the telemedicine service is being furnished through a telecommunications system. FQHCs that serve as an originating site for telemedicine services are paid an originating site facility fee. Charges for the originating site facility fee may be included on a claim, but the originating site facility fee may not be included on the cost report.

FQHCs may receive the encounter rate when billing as a distant site provider if the service being billed is encounter eligible. Clients enrolled in an agency-contracted MCO must contact the MCO regarding whether or not the MCO will authorize telemedicine coverage.

See the Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide.

How do I bill for more than one encounter per day?

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:

- The client needs to be seen by different practitioners with different specialties.
- 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," the time of both visits in the *Claim Note* section, and the appropriate modifier for the service provided.

When billing two different claims for the same date of service, a modifier must be entered on at least one of the claims. The same modifier cannot be used on the first and second claim. The agency must fully process the first claim before the provider submits the second.

Documentation for all encounters must be kept in the client's file.

What procedure codes must an FQHC use?

FQHCs **must** submit claims using the appropriate procedure codes listed in one of the following Washington Apple Health program-specific billing guides, as applicable:

- Dental-Related Services Billing Guide
- Maternity Support Services/Infant Case Management Billing Guide
- Orthodontic Services Billing Guide
- Physician-Related Services/Healthcare Professional Services Billing Guide
- Prescription Drug Program Billing Guide
- Other applicable program-specific provider billing guides

Claims must be submitted on the appropriate claim form:

- Medical services, Maternity Support Services, Infant Case Management, substance use disorder, and mental health on an 837P HIPAA-compliant claim or professional DDE claim
- Dental services on an 837D HIPAA-compliant claim or dental DDE claim
- Pharmacy claims through the Point-of-Sale (POS) system

Can FQHCs get paid for noncovered services?

Noncovered services are not eligible for payment, including encounter payments. Specific information regarding noncovered services can be found under *"What services are noncovered?"* in the Physician-Related Services Billing Guide.

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 as follows:

  - ✓ 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 codes must bill servicing taxonomy appropriate for the service performed by the performing/rendering provider.

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

  - ✓ Maternity Support Services/Infant Case Management providers must bill servicing taxonomy 171M00000X. Childbirth education providers must bill servicing taxonomy 174400000X.

  - ✓ Outpatient substance use disorder treatment providers must bill servicing taxonomy 261QR0405X when billing for substance use disorder services.

  - ✓ Medical and maternity services require a servicing taxonomy appropriate for the service 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, FQHCs 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.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

The following claim instructions relate to FQHCs:

Name	Entry
Place of Service	These are the only appropriate codes for FQHCs: **Code** — **To Be Used For** 03 — School-based 04 — Homeless shelter 11 — Office or ambulatory surgery center 12 — Client's residence 19 — Off-campus outpatient hospital 21 — Inpatient hospital* 22 — On-campus outpatient hospital 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**
Rendering (Performing) Provider	Enter the provider NPI and service-specific taxonomy code
Billing Provider	Enter your billing NPI and FQHC taxonomy code 261QF0400X

* Services performed in this place of service are not encounter-eligible. Do not bill encounter code T1015 for this place of service

** Only use place of service "99" when no other code is available. Details on the place of service may be requested for claims with the code "99."

Note: Services provided to patients in a prison/correctional facility, or place of service (09), are not encounter-eligible. A patient in a prison/correctional facility is not Medicaid eligible.

How do I handle crossover claims in an FQHC setting?

See the ProviderOne Billing and Resource Guide for details on payment methods.

FQHCs do not receive an encounter payment when billing a crossover claim. The payment methodology for these claims is spelled out in the *ProviderOne Billing and Resource Guide*.

> **Note:** FQHC crossover claims will not exceed the co-insurance amount. They do not follow the same methodology as other claims.

FQHCs are required to bill crossover claims on electronic institutional claims. If the Managed Medicare or Medicare Part C plan requires services to be billed on a professional claim, and the services are paid or the money is applied to the deductible, FQHCs must switch the claim information to an electronic institutional claim in order for the claim to process correctly. These crossover claims must be billed to the agency using the Type of Bill 77X and the FQHC taxonomy for the Billing Provider.

How do I handle Managed Medicare or Medicare Part C crossover claims for dental billing?

Managed Medicare and Medicare Part C plans increasingly offer dental services as a covered service. If the Part C plan makes a payment, FQHCs will bill the agency on an electronic dental claim. To ensure the claim goes to Coordination of Benefits for proper pricing, indicate on the claim in the *Claim Note* section that this is a Managed Medicare or Medicare Part C service.