



# **Vermont Medicaid Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC) Supplement**

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## **Section 1 Introduction**

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) have at least two provider numbers: one for services paid using an all-inclusive encounter payment rate, and one for services paid per fee schedule. For all intents and purposes an encounter claim, and payment should include all services provided to a VT Medicaid member with very few exceptions. See section 2.1.2 for a list of exceptions.

## Section 2 Billing Information

### 2.1 Encounters

An Encounter at an FQHC/RHC is defined as a face-to-face visit between a member and a provider. Face-to-face visits with more than one provider and multiple visits with the same provider that take place on the same day and in the same location constitute a single visit, except when one of the following conditions exists

1. After the first encounter, the member suffers illness or injury requiring additional diagnosis or treatment
2. The patient has a medical visit with a physician, physician assistant, nurse practitioner, nurse midwife, or a visiting nurse, and a visit with a clinical psychologist, clinical social worker, or other health professional for mental health services. *Vermont Medicaid follows the same list of health professionals as Medicare.*

Centers must bill procedure code T1015 for the encounter in addition to CPT/HCPCS codes for all services provided during their visit. The T1015 encounter code is to be billed with a zero-charge amount or a negligible charge amount (i.e., \$.01 or \$1.00) if the software prohibits using a zero-charge amount. CPT/HCPCS codes for the services must be billed using your usual and customary charge.

#### 2.1.1 Encounter Examples

1. The member is treated for a headache in the morning at the office and returns home. The member returns to the same office a few hours later because the headache is worse, sees the same or a different practitioner, and returns home. The member returns for the third time to the same office for the same problem and is treated by a third physician and returns home.
  - *This must be billed and reimbursed as one encounter since the encounters were for the same diagnosis at the same location on the same day.*
2. The member is treated during a single visit for both a headache and stomachache.
  - *This must be billed and reimbursed as one encounter.*
3. The member is treated in the morning for a headache and returns home. The member returns the same day for treatment of a laceration.
  - *This is billed and reimbursed as two separate encounters. When the member has left the office and returns for an unrelated reason, then the service can be billed and reimbursed as a second encounter.*
4. The member is treated by a physician and a mental health provider on the same day.
  - *This is billed and reimbursed as two separate encounters, even if the diagnoses are substantially the same, because one encounter is with a medical provider and the other is with a mental health provider.*
5. The member sees her OB for a standard pre-natal visit and returns home. The member returns the same day to see her OB for a separate, pre-natal concern.
  - *Neither of these antepartum (pre-natal) visits with an OB are considered an encounter by Vermont Medicaid. Antepartum care visits are typically billed globally after the birth.*

## 2.1.2 Exceptions

The below exceptions are billed fee-for-service. If the service provided does not fall into one of the below categories and is not further defined within the FQHC/RHC Supplement, then the reimbursement for the service is included within the encounter rate:

- OB Care
- Labs
- Radiology, including technical components
- Dental
- Group Therapy/Group Psychotherapy
- DME (A DME Provider Number is required to bill for these separately)
- LARC/IUD: The device is billed Fee-for-service. The insertion and removal are billed as an Encounter.
- Chronic Care Management (G0511)
- Other Services: (completing DVHA treatment plans or refugee forms, providing Healthy Babies services or planning for an IEP)

**Vaccine Administration** is included in the encounter rate:

- If the member has a clinic visit the same day, do not submit a separate claim for vaccines or vaccine administration as it is included in the encounter rate.
- If the member presents for only a vaccine and there is no clinic visit that day bill Fee for Service as there would be no E&M code/encounter.

## 2.2 Hospital or Nursing Home Services

FQHC/RHC provider services delivered at hospitals may be billed as either encounters or fee for service. The billing method used must be consistent throughout the fiscal year.

- Encounter billing: Use the facility number if the services are billed as encounters. The time spent by the provider should be attributed to the same account.
- Fee for Service billing: Use the non-FQHC/RHC provider number and service billed with the appropriate CPT code.
- FQHC/RHCs shall report the method used to the cost report auditor.

## 2.3 Specimen Collection Fee

Payment for obtaining specimens is included in the reimbursement of the office visit. Physicians may bill Vermont Medicaid for a specimen collection fee in two situations only: for the collection of blood via venipuncture or for the collection of a urine sample by catheterization. Federal Qualified Health Clinics and Rural Health Clinics have different guidelines for this process:

- Venipuncture (or blood draw fee) and the specimen handling fee are included as part of FQHC services. They are not considered part of the diagnostic laboratory services.
- Blood draws/venipuncture and specimen handling provided by nurses or technicians for services, such as lab tests and blood draws, do not bill an encounter. These charges are included within the encounter payment when the service was originally ordered. Clinical Diagnostic Laboratory tests performed on-site should be billed separately as a fee for service.

- Laboratory services provided by an FQHC or RHC should be billed using the non-FQHC/RHC provider number. These services are paid per the fee schedule.

## **2.4 Interpreter Services/Limited English Proficiency (LEP)**

See the Vermont Medicaid General Billing and Forms Manual, Section 4.9, Interpreter Services/Limited English Proficiency (LEP) for additional information.

<http://www.vtmedicaid.com/#/manuals>

- FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers.
- When a member receives services that are not eligible for reimbursement, the interpreter services are ineligible for reimbursement.

## **2.5 Radiology**

See the Vermont Medicaid General Billing and Forms Manual, Section 5.3.47, Radiology for additional information. <http://www.vtmedicaid.com/#/manuals>

- Radiology services, except dental films, should be billed using the non-FQHC/RHC provider number.

## **2.6 Dental Services**

See the Vermont Medicaid Dental Supplement for additional information.

<http://www.vtmedicaid.com/#/manuals>

- Dental services provided by FQHC should be billed using the appropriate dental code and the FQHCs dental provider number. These services are paid on the Vermont Medicaid fee schedule but will be cost settled at year end.

## **2.7 Durable Medical Equipment (DME)**

See the Vermont Medicaid DME Supplement for additional information.

<http://www.vtmedicaid.com/#/manuals>

- DME items are to be billed using the appropriate HCPCS codes and would be reimbursed per the fee schedule. A DME Provider Number is required to bill DME items. Your facilities NPI and taxonomy number must indicate that you are a licensed DME provider. A copy of your NPI letter will be required at time of enrollment.

## **2.8 Other Services**

When an FQHC or RHC bills for completing DVHA treatment plans or refugee forms, providing Healthy Babies services or planning for an IEP, the service should be billed using the non-FQHC/RHC number.

Minor equipment and supplies (such as band-aids and ace bandages) are assumed to be part of the encounter and are not eligible for reimbursement on an individual basis.

## **2.9 Coverage Review**

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. Coverage reviews are initiated when a written prior authorization (PA) request is received by DVHA from a Vermont Medicaid enrolled provider for any Vermont Medicaid beneficiary.

DVHA does not review requests for coverage by a manufacturer, a manufacturer's representative, a Durable Medical Equipment vendor, or other third parties.

Refer to the Fee Schedule at <https://dvha.vermont.gov/providers/codesfee-schedules> for information about the code coverage and if the specific code in question, requires prior authorization. Questions about this policy can be directed to the DVHA Clinical Operations Unit at 802-879-5903.

## **2.10 Interim Dental Settlements**

After an FQHC or RHC files a cost report, it can request that an interim settlement be made, for dental services, by sending a letter either to DVHA or the DVHA auditor requesting such. DVHA will pay up to 90% of the balance due to the facility, based on the recommendations of the auditor.

## Section 3 Other Insurance

If an FQHC/RHC provides one or more services on the same day to a Vermont Medicaid member with insurance other than Medicare, the visit should first be billed to the other insurer using the appropriate CPT code(s). The facility may bill Vermont Medicaid for the balance between the other insurance payment and the facility's encounter rate using T1015 as the encounter code. (Refer to the instructions for Section 29 of CMS-1500 form.)

Insurance plans impose various rules for members covered by their plan including a commercial HMO. If a Vermont Medicaid member has other insurance, the member must follow the rules (such as network limitation) of that insurer. Vermont Medicaid will not make a payment for which another insurer is responsible or would be responsible if the member had followed that insurer's rules.

If the other insurer requires a co-payment for office visits that are paid under the capitated rate, Vermont Medicaid will reimburse the provider for this office visit co-pay charge only. To bill the co-pay amount, use procedure code T1015. If FQHC/RHC's wish to bill for the co-pay for visits under capitation, they can claim a T1015 but must use the non-FQHC/RHC provider number.



## Section 4 Scope-of-Service Related Encounter Rate Adjustments

An FQHC or RHC may apply to the Department of Vermont Health Access (DVHA) for adjustment of its prospective payment system (PPS) encounter rate in accordance with the following requirements.

### 4.1 General

An adjustment in PPS encounter rate will be considered when there has been a HRSA-approved change in scope of project (“scope-of-project change”) that gives rise to a change in type, intensity, duration and/or the amount of services delivered by the FQHC or RHC (a “scope-of-service change”). Proof of HRSA approval of the scope-of-project change must be supplied by the FQHC or RHC as supporting documentation for the encounter rate adjustment request.

### 4.2 Additional Qualifying Criteria

A change in costs, in and of itself, will not be considered a scope-of-service change unless all of the following apply:

- The increase or decrease in cost is attributable to an increase or decrease in the scope of FQHC or RHC services.
- The cost is allowable under the Medicare reasonable cost principles set forth in 42 CFR Part 413.
- The change in scope of service is a change in type, intensity, duration, or amount of service.
- The cost attributable to the scope-of-service change must account for an increase or decrease to the current cost per encounter greater than or equal to three percent (3.0%) net of any applicable cost offsets.

### 4.3 Vermont Medicaid Scope-of-Service Change Types

Potential encounter rate changes based on a scope-of-service change will be evaluated in accordance with Medicare cost principles set forth in 42 CFR Part 413. Subject to the conditions set forth in the preceding paragraph, a scope-of-service change means any the following:

- The addition of a new FQHC or RHC service that is not incorporated into the existing baseline PPS encounter rate, or the deletion of an FQHC or RHC service that is included in the existing baseline PPS encounter rate.
- The addition of professional staff licensed and hired to perform services that no other currently employed professional staff member performs.
- The departure of a licensed professional staff member that leaves no other licensed professional staff member performing those services currently provided by the departing staff member.
- A change in service due to amended federal or state regulatory requirements and/or a State of Vermont initiative that would impact FQHC or RHC costs.
- A change related to health information technology.
- An increase or decrease in service intensity attributable to changes in the types of patients served, including but not limited to populations with chronic diseases, or homeless, elderly, migrant or other special populations.

- Changes in any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, or in the provider mix of an FQHC or RHC or one of its sites.

#### **4.4 Request for Review**

FQHCs and RHCs must notify the DVHA Reimbursement Unit of any scope-of-project change, any scope-of-service change, or any requested PPS encounter rate adjustment based thereon. FQHCs and RHCs can request a PPS encounter rate adjustment based on a qualifying scope-of-service change once per calendar year. Notwithstanding anything to the contrary in this section, DVHA reserves the right to initiate a change-in-scope review for any reason, and for avoidance of doubt, shall not be limited to circumstances in which there has been a HRSA approved scope-of-project change.

The FQHC or RHC shall submit to the DVHA Reimbursement Unit the following required documentation with any request for a PPS encounter rate adjustment:

- Cost report.
- Written request for review (including as applicable the description of and reason for the change including a description of why the service is needed, the population(s) impacted, impact on operating cost specifically related to each change in scope of service, anticipated date services will begin, and all documentation submitted to HRSA).
- The estimated number of Vermont Medicaid members that will be impacted, the number of total encounters anticipated on an annual basis for all Vermont Medicaid members, and an explanation/justification for the cost of providing care.
- Documentation that HRSA has approved the change in scope of the project giving rise to the request.
- Audited financial statements.
- A detailed listing of all new cost(s) and cost offsets, if any, directly related to each qualifying change in scope.

The DVHA Reimbursement Unit will review all scope-of-service change-related requests for rate adjustment along with supporting documentation and will issue its decision within 90 days of receipt. If a change in rate is granted, the new rate will be implemented on a prospective basis. All rate adjustments will be implemented on the 1st of the month. Rate adjustments resulting from requests received prior to the 15th of the month will be effective on the 1st of the month immediately following the decision (4th month). Rate adjustments resulting from requests received after the 15th of the month will not take effect until the 5th month due to MMIS implementation timeframes. DVHA Reimbursement reserves the right to extend review times for extenuating circumstances.

Adjusted encounter rates will be based on the reasonable costs associated with the scope-of-service change forming the basis of the request, as determined by the DVHA Reimbursement Unit. DVHA reserves the right to adjust encounter rates in connection with any DVHA-initiated reviews of scope-of-service changes.