TABLE OF CONTENTS

SECTION 31 FEDERALLY QUALIFIED HEALTH CENTER SERVICES 9/1/85
Last updated 11/29/10

31.01 DEFINITIONS

31.01-1 **Ambulatory services** are services provided by a federally qualified health center other than those core services described in Section 31.04-1 that are also included in the State's Medicaid Plan and that are provided in accordance with all applicable sections of the MaineCare Benefits Manual. This includes dental services provided by dentists, dental hygienists, and licensed dental entities.

31.01-2 **Covered services** are those services described in Section 31.04 for which payment can be made under Title XIX and XXI by the Department of Health and Human Services.

31.01-3 **Federally Qualified Health Center (FQHC)** refers to a facility or program that is federally qualified and may also be known as a community health center, migrant health center, or health-care program for the homeless. A center is "federally qualified" if it:

A. is receiving a grant under Section 330 of the Federal Public Health Service (PHS) Act;

B. is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;

C. is determined by the Secretary of the Department of Health and Human Services, to meet the requirements for receiving such a grant (look-alike), based on the recommendation of the Health Resources and Services Administration (HRSA) within the Public Health Service;

D. was treated by the Secretary (of Health and Human Services), for purposes of Medicare Part B, as a comprehensive federally funded health center as of January 1, 1990; or

E. is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

31.01-4 **Federally Qualified Health Center Services** are those primary health-care (core services) and other ambulatory services furnished by the facility's professional staff during a visit.

31.01-5 **Homebound member** is defined as an individual who is confined permanently or temporarily to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or long-term care facility.

31.01 **DEFINITIONS** (cont.)

31.01-6 **Plan of treatment** is a written plan of medical services for part-time or intermittent visiting nurse care that is established and reviewed at least every sixty (60) days by a supervising physician of the health center. When delegated by the supervising physician, and when in compliance with all other State licensure requirements, it may also be established by a physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every sixty (60) days by a supervising physician of the health center.

31.01-7 **Primary health care** refers to preventative, diagnostic and therapeutic services furnished by the health center's professional staff and, where appropriate, the supplies commonly used to support those services, basic laboratory services essential for diagnosis and treatment, and emergency medical care for the treatment of life-threatening injuries and acute illness.

31.01-8 **FQHC unit of service** is a visit that includes a face-to-face contact with one or more of the center's core or ambulatory professional staff and, where appropriate, receipt of supplies, treatments, and laboratory services.

31.01-9 **Incidental Services and Supplies** refer to certain services and supplies authorized by licensed medical, dental and mental health practitioners.

31.02 **ELIGIBILITY FOR CARE**

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

It is the responsibility of the provider to verify a member's eligibility for MaineCare as described in Chapter I.

31.03 **DURATION OF CARE**

Each Title XIX and Title XXI member may receive as many covered services as are medically necessary. The Department reserves the right to request additional information to evaluate medical necessity.

31.04 **COVERED SERVICES**

All services must be provided within the HRSA-approved scope of service area, or to HRSA-Designated Medically Underserved Populations (MUP) at federally approved center locations such as school-based health centers, and be otherwise provided in conformance with Federal requirements.

31.04 **COVERED SERVICES** (cont.)

Covered services include core services, and other ambulatory services contained in the State's Medicaid plan, and in the FQHC's scope of project for base year 1999 as approved by HRSA, either as amended, or as specifically approved by the Commissioner of the Maine Department of Human Services (DHS). FQHCs must submit their HRSA-approved scope of project for base year 1999, or if established after 1999, for their first year of operation, and all subsequent HRSA-approved amendments to scope of project.

31.04-1 **Core services** include:

A. services provided by physicians, physician assistants, advanced practice registered nurses, clinical psychologists, licensed clinical social workers, and licensed clinical professional counselors;

B. services and supplies furnished as incident to services of approved and appropriate licensed practitioners. In order for incidental services to be covered, FQHC employees must perform the incidental service, unless it is an FQHC service routinely performed by contracted personnel or providers. Services provided by auxiliary personnel not in the employ of the FQHC, even if provided on the physician's order or included in the FQHC's bill, are not covered as incident to a physician's service. Thus, non-physician diagnostic and therapeutic services that an FQHC obtains, for example, from an independent laboratory, an independent licensed or otherwise qualified provider, or a hospital outpatient department are not covered FQHC services;

C. visiting nurse services (as described in Section 31.04-4).

31.04-2 **Ambulatory services** include the following:

A. Any other ambulatory service, including any incidental supplies associated with the performance of a service that is provided by the FQHC, and that is also included in the State's Medicaid Plan, are reimbursable. (These services must be provided in accordance with all applicable sections of the MaineCare Benefits Manual in order to be reimbursable.);

B. Asthma self-management services are reimbursable if they are based on the Open Airways or Breathe Easier curricula. Any other asthma management service that is approved by the National Heart, Lung and Blood Institute/American Lung Association or the Asthma and Allergy Foundation of America, are also reimbursable.

Each program must have:

1. a physician advisor;

31.04 **COVERED SERVICES** (cont.)

2. a primary instructor (a licensed health professional or a health educator with baccalaureate degree);

3. a pre and post assessment for each participant which shall be kept as part of the member's record;

4. an advisory committee which may be part of an overall patient education advisory committee; and

5. a physician referral for all participants.

C. Reimbursement for Ambulatory Diabetes Education and Follow-Up (ADEF) Services, or for similar services approved by a Centers for Medicare and Medicaid Services (CMS) approved national accreditation organization, will be reimbursed when a provider enrolled with the Maine Diabetes Control Project furnishes this service to a MaineCare member whose physician has prescribed this program for the management of the member's diabetes. The service is:

1. a pre-assessment interview to determine the member's knowledge, skills and attitudes about diabetes management and to develop an individualized education plan and behavior change goals;

2. a group class instruction covering the comprehensive curriculum outlined by the Maine Diabetes Control Project and based on the individualized education plan;

3. a meal planning interview to determine the member's knowledge, skills and attitudes about meal planning and to develop an individualized meal plan and behavior change goals;

4. a post-service interview to assess and document what the member has learned during the service, and to develop a plan for follow-up sessions to address the component areas not learned in the class series, and finalize behavioral goals; and

5. follow-up contacts to reassess and reinforce self-care skills, evaluate learning retention and progress toward achieving the member's behavior change goals. At a minimum, three-month, six-month, and one-year follow-up visits from the date of the last class are required to complete the member's participation in the service.

31.04 **COVERED SERVICES** (cont.)

When the MaineCare member is under age 21, this service will also be reimbursed when provided to the person/people who provide the member's daily care.

D. Smoking Cessation Counseling will be reimbursed for up to three (3) sessions per calendar year, per member, per physician or other provider who is licensed to prescribe. Smoking cessation counseling may be billed alone, or in combination with other FQHC services. Documentation of the smoking cessation counseling must be contained in the medical record. Documentation must include:

1. an ICD-9 diagnosis code of 305.1 (tobacco use disorder);

2. an assessment of the member's willingness to quit smoking, or of his or her progress in quitting;

3. documentation of any ongoing barriers to quitting or staying tobacco-free; and

4. a brief outline of whatever motivational or educational information was provided.

5. the name and license level of person providing the smoking cessation services.

31.04-3 **Off-site delivery of services** furnished by health center staff are reimbursable when they are provided away from the center and when it is documented in the member's chart that it is the most clinically appropriate setting for the provision of services. Examples of off-site service locations include: a nursing facility, an emergency room, an inpatient hospital, or a member's home.

31.04-4 **Visiting nurse services** will be reimbursed when:

A. a registered nurse or licensed practical nurse provides the services to a member who is homebound;

B. the services are provided in accordance with a written plan of treatment;

C. the member's record documents that the member would not otherwise receive these services;

D. the services are provided in an area for which the Secretary of the US Department of Health and Human Services has determined there is a shortage of home health agencies; and

31.04 **COVERED SERVICES** (cont.)

E. the health center that provides in-home services by a registered or licensed practical nurse is licensed by the State of Maine as a home health service provider.

31.04-5 **Interpreter Services** - Refer to Chapter I of the MaineCare Benefits Manual for information about the reimbursement for interpreter services.

31.05 **NONCOVERED SERVICES**

Unless the Commissioner of DHHS specifically approves an additional service, covered services are limited to those services HRSA approved in the FQHC's scope of project. See Chapter I of the MaineCare Benefits manual for additional details on non-covered services.

31.06 **POLICIES AND PROCEDURES**

31.06-1 **Professional Staff**

In order for a Federally Qualified Health Center to receive reimbursement, its professional staff must be conditionally, temporarily or fully licensed, in the state or province where services are provided, as documented by written evidence from the appropriate governing body, including: physicians, podiatrists, physician assistants, advanced practice registered nurses, clinical psychologists, clinical social workers, clinical professional counselors, registered nurses, licensed practical nurses, respiratory therapists, dentists and dental hygienists. MaineCare will also reimburse for advanced practice or registered nurses who hold a current, unencumbered compact license from another compact state that they claim as their legal residence. Qualifications of any other staff must be provided and billed in accordance with all other applicable sections of the MaineCare Benefits Manual.

Effective 11/29/10

31.06-2 **Supervision by a Physician**

Medical services rendered under this policy must be provided under the supervision of a physician, or other suitably licensed practitioner, to the extent required by applicable state or provincial laws or regulations. Clinical psychologists, LCSWs, LCPCs, dentists, and other non-medical staff are not subject to the supervision of the physician.

Physician supervision must be performed in accordance with the Maine Board of Licensure in Medicine or the Maine Board of Licensure in Osteopathy requirements.

31.06-3 **Member Records**

There shall be a specific record for each member, which shall include, but not necessarily be limited to:

31.06 **POLICIES AND PROCEDURES** (cont.)

A. the member's name, address and birth date;

B. the member's social and medical history, as appropriate;

C. a description of the findings from the physical examination;

D. long- and short-range goals, as appropriate, except for clinical psychologist, licensed clinical social worker and licensed clinical professional counselor services, where a mental health treatment plan containing long- and short-term goals and signed by both the provider and the member, must be developed by the third session, and updated with signatures at least quarterly thereafter;

E. a description of any tests ordered and performed and their results;

F. a description of treatment or follow-up care and dates scheduled for revisits;

G. any medications and/or supplies dispensed or prescribed;

H. any recommendations for and referral to other sources of care;

I. the dates on which all services were provided; and

J. written progress notes, which shall identify the services provided and progress toward achievement of goals.

K. for members with a history of chronic mental illness, who receive ongoing outpatient therapy by LCSWs, LCPCs, psychologists or advanced practice psychiatric nurses, or who receive medication management from advanced practice psychiatric nurses, the following additional record-keeping requirements apply:

1. Initial Assessment/Clinical Evaluation. An initial assessment, which must include a direct encounter with the member, and his/her family if appropriate, shall be performed and included in the member's FQHC record. The assessment must include the member's medical and social history and must include the member's diagnosis and the professional who made the diagnosis and that person's credentials.

2. Individual Treatment/Service Plan. An individual treatment/service plan must be developed by the third mental health visit. This individual treatment/service plan shall be in writing and shall identify mental health treatment needs, and shall delineate all specific services to be provided, the frequency and duration of each service, the mental

31.06 **POLICIES AND PROCEDURES** (cont.)

health personnel who will provide the service, and the goals and/or expected outcomes of each service. Treatment plans must be reviewed and approved by a psychiatrist, physician, psychologist, or licensed clinical social worker, licensed clinical professional counselor or advanced psychiatric and mental health nurse, or a registered nurse certified in the specialized field of mental health within thirty (30) days of entry of the member into mental health treatment.

3. Written treatment or progress notes shall be maintained in chronological order, and shall be made for each mental health visit. These notes shall identify who provided the service, the provider's credentials, on what date the service was provided, its duration, and the progress the member is making toward attaining the goals or outcomes identified in the treatment plan.

4. The clinical record shall also specifically include written information or reports on all medication reviews, medical consultations, psychometric testing, and collateral contacts made on behalf of the member (name, relationship to member, etc.).

5. In cases where FQHC mental health services are needed in excess of two hours per week to prevent hospitalization, documentation must be included in the file and signed by a psychiatrist, physician, psychologist, licensed clinical social worker, licensed clinical professional counselor or psychiatric nurse.

6. Discharge/Closing Summary. A closing summary shall be signed and dated and included in the clinical record of discharge treatment and outcome in relation to the individual treatment/service plan.

7. In the event a member receives group services, there shall be no names of other group participants in the member's record.

Entries are required for each service billed and must include the name, credentials, and signature of the service provider. See Chapter I of the MaineCare Benefits Manual for additional record keeping requirements.

31.06-4 **Program Integrity**

Please see Chapter I of the MaineCare Benefits Manual.

31.07 **REIMBURSEMENT**

31.07-1 General FQHC Reimbursement

Reimbursement for Federally Qualified Health Center services is made on the basis of "reasonable cost" as determined by the Medicare Principles of Reimbursement. Reimbursement will be made for services provided in accordance with these rules.

Effective January 1, 2001, federally qualified health centers will be reimbursed on the basis of 100% of the average of their reasonable costs of providing MaineCare-covered services during calendar years 1999 and 2000, adjusted to take into account any increase or decrease in the approved scope of services furnished during the provider's fiscal year 2001 (calculating the amount of payment on a per visit basis). At the start of each subsequent year, beginning in CY 2002, each FQHC is entitled to the payment amount (on a per visit basis) to which the center was entitled under the Act in the previous fiscal year, inflated by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in any rate adjustment for the approved scope of service changes furnished during that fiscal year. Until the initial new payment rate is calculated according to this methodology, federally qualified health centers will be paid at their current plan rate, which will be retroactively adjusted once the new payment rate is calculated. Newly qualified FQHCs after fiscal year 2000 will have initial payments established either by reference to payments to other centers in the same or adjacent areas, or in the absence of such other centers, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other centers.

Federally qualified health centers are required to file a Medicare annual cost report with appropriate addenda to the Department of Health and Human Services Division of Audit within one hundred and fifty (150) days of their fiscal year end, unless an extension has been granted before the one hundred and fifty (150) days has expired by the Division of Audit. In addition, FQHCs must notify the Division of Audit on a timely basis if the year-end for the agency changes. Cost reports must be submitted to the Division of Audit, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011. Furthermore, for the purpose of establishing baseline information on FQHCs, FQHCs must submit their HRSA Plan of Project for the Fiscal Year 1999, or for their first year of operation for FQHCs approved after Fiscal Year 1999, plus any subsequent approved Plan of Project amendments.

An FQHC request for a rate adjustment due to a substantial change in the type of service provided (equivalent to a change in scope of project) must be received no later than one hundred and fifty (150) days after the FQHC's fiscal year end in which the change in scope occurred. The FQHC will be required to submit documentation showing that the Health Resources and Services Administration (HRSA) had approved its change in scope of project, and a cost report reflecting at least six (6) months of financial data and narrative documenting the change. The Department will respond to the Health Center's request for a rate adjustment within

31.07 **REIMBURSEMENT (cont)**

sixty (60) days. If the Department determines that a related rate adjustment is warranted, the incremental cost per encounter from this change may be added to the calculations that set the existing rate, and a new rate may be established. This new rate will be based on the reasonable costs associated with the CMS-approved changes as determined by the Department, and will become effective on the date the change of scope was implemented by the FQHC.

An FQHC change in scope of service may also be based on a change specifically approved by the Commissioner of the Department of Health and Human Services.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to ascertain from each member whether there are any other resources (private or group insurance benefits, workers' compensation, etc.) that is available for payment of the rendered service, and to seek payment from such resources prior to billing MaineCare.

Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. Reimbursement for a second core visit is also covered if the member has both an encounter with a physician, physician assistant, advanced nurse practitioner or visiting nurse, and in addition to that encounter, is seen by a licensed clinical psychologist, clinical social worker, clinical professional counselor or a clinical nurse specialist licensed as a psychiatric registered nurse on the same day. An additional visit of any other kind will only be reimbursed for unforeseen circumstances as documented in the member's record. The goal remains to treat the whole individual during one visit.

Federally qualified health centers may be reimbursed in excess of their core and additional (same day) visit rates when providing the following services delineated in the respective sections of the MaineCare Benefits Manual: Primary Care Case Management Services per Chapter VI, Section 1; and Chapter 1.

Any additional center visits that are required in the patient's treatment plan that do not qualify as center visits for reimbursement purposes are non-billable.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from other third party payers prior to billing MaineCare for a rendered service.
If a member has capitated third party coverage other than MaineCare, and if that third party carrier requires a member co-pay but makes no fee-for-service payment to cover FQHC services, MaineCare reimbursement will be limited to the amount of the co-pay alone.

Centers have the option of obtaining a separate MaineCare provider billing number for the limited purpose of fee-for-service billing and reimbursement for such services as x-ray, EKG, inpatient hospital visits and other Medicare defined non-FQHC services that are billable under Medicare Part B. If a center chooses to bill fee for service for these Medicare defined non-FQHC services, they may not report costs related to these services on their MaineCare cost report.

31.07 **REIMBURSEMENT (cont)**

31.07-2 Reimbursement for Members Eligible for both Medicare and MaineCare

For members who are eligible for both Medicare and MaineCare services, MaineCare will provide reimbursement to providers as follows:

(a) Qualified Medicare Beneficiaries without other Medicaid (QMB only)

After Medicare has completed its payment, the provider may bill MaineCare and MaineCare will pay the remaining amount up to the Medicare rate (including co-insurance), for Medicare only services.

(b) Qualified Medicare Beneficiaries with Medicaid (QMB Plus)

For services covered by Medicare, after Medicare has completed its payment, the provider may bill MaineCare and MaineCare will pay the remaining amount (including co-insurance) up to the MaineCare rate. For services only covered by MaineCare, MaineCare will pay all MaineCare expenses.

(c) Non-Qualified Medicare Beneficiaries (non-QMBs)

After Medicare has completed its payment, the provider may bill MaineCare and MaineCare will pay for covered MaineCare services provided by MaineCare providers but only to the extent that the MaineCare rate exceeds any Medicare payment for any service covered by both Medicare and MaineCare.

31.08 **COPAYMENT**

A. Providers will charge a copayment to each MaineCare member receiving services, unless the member is exempt under the provisions of Chapter I of the MaineCare Benefits Manual. The amount of the copayment shall not exceed $3.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 - 50.00	$2.00
$50.01 or more	$3.00

B. The member shall be responsible for copayments up to $30.00 per month whether the copayment has been paid or not. After the $30.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services. Providers are subject to the Department's copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.

31.09 **BILLING INSTRUCTIONS**

Effective 11/2910

Upon the implementation of MIHMS, providers billing for FQHC services must bill using standard CPT and HCPC procedure codes as detailed in Chapter III, Section 31, Table 1. For Core and Ambulatory Services, as described under Covered Services-Section 31. 04, providers must bill T1015 and include the appropriate revenue codes. When billing, providers must use a UB 04 claim form. Effective October 1, 2010, in addition to billing the code T1015 for Core and Ambulatory Services, providers must also report all services provided including all procedures with the standard CPT and HCPC5 codes on the UB 04 claims form for reporting pruposes.