



KANSAS MEDICAL ASSISTANCE PROGRAM
Fee-for-Service Provider Manual

Rural Health Clinic/
Federally Qualified
Health Center

PART II

**RURAL HEALTH CLINIC AND
FEDERALLY QUALIFIED HEALTH CENTER
FEE-FOR-SERVICE PROVIDER MANUAL**

Introduction

Section	BILLING INSTRUCTIONS	Page
7000	CMS 1500 Claim Form.	7-1
	BENEFITS AND LIMITATIONS	
8100	Copayment	8-1
8300	Benefit Plans	8-2
8400	Medicaid	8-3

FORMS All forms pertaining to this provider manual can be found on the [public](#) website and on the [secure](#) website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the [KanCare](#) website. Contact the specific health plan for managed care assistance.

CPT® codes, descriptors, and other data only are copyright 2021 American Medical Association (or such other date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply. Information on the [American Medical Association](#) is available.

PART II

**RURAL HEALTH CLINIC AND
FEDERALLY QUALIFIED HEALTH CENTER**

Updated 01/18

This is the provider specific section of the manual. This section of Part II was designed to provide information and instructions specific to Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers. It is divided into two subsections: Billing Instructions and Benefits and Limitations.

Billing Instructions contains instructions on completion and submission of the CMS 1500 Claim Form.

Benefits and Limitations defines specific aspects of the scope of services covered within the Kansas Medical Assistance Program (KMAP).

Access to Records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance

Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER

7000. Updated 01/18

Introduction to the CMS 1500 Claim Form

Providers must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider.

An example of the CMS 1500 Claim Form and instructions are available on the KMAP [public](#) and [secure](#) websites under the Publications tab on the [Forms](#) page under the Claims (Sample Forms and Instructions) heading.

Any of the following billing errors may cause a CMS 1500 Claim Form to deny or be sent back to the provider:

- Sending a KanCare paper claim to KMAP.
- Sending a CMS 1500 Claim Form carbon copy.
- Using a PO Box in the Service Facility Location Information field.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

SUBMISSION OF CLAIM

Send completed claim and any necessary attachments to:

KMAP
Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

For information on KAN Be Healthy - Early Periodic Screening, Diagnosis, and Treatment (KBH-EPSDT) and billing for screens, reference the *KAN Be Healthy - Early Periodic Screening, Diagnostic, and Treatment Provider Manual*.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 01/18

RHC services require a copayment of \$2 per encounter.

FQHC services require a copayment of \$3 per encounter.

Bill all services occurring on the same date on the same claim form.

If multiple claims are submitted for the same date(s) of service, the copayment requirement will be deducted for each claim submitted.

Do not reduce charges or balance due by the copayment amount. This reduction is automatically made during claim processing.

BENEFITS AND LIMITATIONS

8300. Benefit Plan Updated 01/18

KMAP beneficiaries will be assigned to one or more benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Fee-for-Service Provider Manual* for information on eligibility verification.

For the MediKan benefit plan, psychotherapy is limited to a maximum of 24 hours per calendar year.

BENEFITS AND LIMITATIONS

8400. Medicaid Updated 01/18

RHC and FQHC services are outpatient primary care services defined in 42 CFR Part 405, Subpart X. KMAP complies with scope, definitions, and criteria set forth in 42 CFR Part 405.2401 through 405.2472 and Publication 27, excluding portions that are specific to Medicare benefit and not applicable to Medicaid. Reimbursement for covered services furnished to eligible beneficiaries is in accordance with the provisions of the Benefits Improvement and Protection Act (BIPA) of 2000.

Enrollment

To enroll as an RHC provider under KMAP, the clinic must be certified and accepted as qualified to furnish RHC services under Medicare and Medicaid by the Centers for Medicare & Medicaid Services (CMS), formerly Health Care Financing Administration (HCFA). To enroll as a FQHC provider, the center must be recommended by the Public Health Services (PHS) as meeting the requirements of section 329, 330, and 340 of the PHS Act, and accepted by CMS as qualified to furnish FQHC services for Medicaid. An RHC/FQHC can be “freestanding” (independent) or “provider-based”.

FQHCs may enroll and bill for services with KMAP as separate and different provider types. Once FQHC providers initiate the enrollment process with the fiscal agent for a different provider type, they will be contacted and requested to submit the additional information. The provider must submit documentation to the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), to explain to KDHE-DHCF how the programs, personnel, accounting system, billing system, and facility square footage will be kept separate and independent for each provider type and how duplicate billing will be avoided.

Providers should send documentation to:

Office of the Fiscal Agent
Provider Enrollment Department
PO Box 3571
Topeka, Kansas 66601-3571

Visit or Encounter

A covered RHC or FQHC “visit” means a face-to-face encounter between a clinic/center patient and a clinic/center health care professional or practitioner (listed below) during which a covered RHC/FQHC service or dental service is rendered:

- Physician
- Physician assistant (PA)
- Advanced practice registered nurse (APRN)
- Nurse midwife
- Dentist (for FQHCs only)
- Clinical psychologist
- Clinical social worker
- Registered nurse (RN), for KBH-EPSDT nursing screen only, bill with modifier TD
- Visiting nurse (if the conditions listed under “visiting nurse services” are fulfilled)
- Registered dental hygienist, extended care permit (RDH ECP)

8400. Updated 05/19

Note: The RDH ECP applies to FQHCs only, not RHCs.

Encounters with more than one health professional, or multiple encounters with the same professional, on the same day constitute a single visit.

Just because a service is covered does not automatically mean it is a billable/covered *visit*. If an encounter does not involve one of the above listed practitioners, it is not a covered RHC/FQHC visit and **should not** be billed.

If an examination of the patient is not performed during a face-to-face encounter, it does not constitute a covered RHC/FQHC visit and **should not** be billed. For example, a visit for the sole purpose of obtaining or renewing a prescription (need for which was determined previously) without a medical examination of the patient is **not** a covered encounter.

Health Care Professional or Practitioner Requirements

The practitioner should either be an employee or an owner of the RHC/FQHC. A qualified practitioner under contractual arrangement to receive compensation from the RHC/FQHC also qualifies. The RN who performs KBH-EPSDT nursing assessments must be an employee of the RHC/FQHC. The RDH ECP who provides dental services away from the center must be an employee/contractor of the FQHC.

More Than One Encounter on the Same Day

If the patient suffers illness or injury subsequent to the first visit on the same day requiring additional diagnosis and treatment which are different from the first visit, the second encounter qualifies as an additional visit.

Subsequent visit on the same day must be medically necessary and include documentation of why the subsequent service could not have been provided during the initial encounter.

When billing for multiple encounters on the same day with different diagnoses and:

- *different procedure codes*, use modifier 25.
- *same procedure code*, use modifier 76 first, followed by modifier 25.

Place-of-Service Criteria

Services at the Clinic or Center

If covered services are furnished by a clinic/center practitioner at the facility, they are payable only to the clinic/center and should not be billed under any other Medicaid provider number.

RHCs are required to use code 72 (rural health clinic) in the place of service (POS) code field and FQHCs are required to use POS code 50 (federally qualified health center). Code 11 (physician's office) will no longer be accepted as the POS code for RHC or FQHC services.

If the RHC or FQHC services are in a setting outside of the clinic, the appropriate POS code must be used. For example, if an RHC or FQHC service is provided in a skilled nursing facility (SNF), POS code 31 is applicable. If an RHC or FQHC service is provided in the home, POS code 12 is applicable. Effective July 1, 2019, code 13 is the billable POS code for assisted living facilities.

FQHCs providing dental services must use POS “Other” for dental services provided in the FQHC. Services that are considered non-RHC and non-FQHC, such as the technical components of radiology, electrocardiogram (EKG), and clinical diagnostic lab services, must be billed as they are currently being billed (using POS code 11).

8400. Updated 01/18

Services Away from the Clinic or Center

If the service is furnished at a location other than the facility (such as the patient's place of residence, the scene of an accident), **the coverage as an RHC/FQHC encounter** depends on whether there is an agreement that the clinic/center would compensate the practitioner for furnishing services in a location away from the clinic/center. The following criteria apply for billing for these services:

- Practitioner Compensated: The service is covered as an RHC/FQHC visit and should only be billed under the RHC/FQHC provider number. It may not be billed under any other Medicaid provider number.
- Practitioner Not Compensated: The service is not covered as an RHC/FQHC visit. It can be billed under the performing provider's individual Medicaid provider number.

Dental services can be provided in an existing dental office away from the center.

- The FQHC must have a contractual arrangement with the dental office for space, services, supplies, etc.
- Dental professionals who provide services away from the center must have a contractual arrangement in place with the FQHC.
- It should be understood (held out to the public) that the services provided are being provided by the FQHC.
- These services provided by the FQHC are billed as an encounter.
- All encounters provided by the RDH ECP professionals while employed/contracted with the FQHC, whether provided to Medicaid, uninsured, or another payer type, are FQHC encounters and must be reported by the FQHC in the total FQHC encounters for the cost report.

Services in a Hospital

Services provided by a clinic/center practitioner in an outpatient, inpatient, or emergency room of a hospital or in a swing-bed do not constitute covered RHC or FQHC services under KMAP. These services may be billed under the performing provider's individual Medicaid provider number.

Note: If these services are rendered during a timeframe for which the practitioner is compensated by the RHC/FQHC for providing services at the clinic/center, all expenditures associated with these services must be carved out on the RHC/FQHC cost report.

Covered Services

Covered services are services and supplies necessary and reasonable for furnishing health care services to patients efficiently and in accordance with applicable rules and regulations. Coverage of a service or supply does not necessarily mean it can be billed by itself. It does mean that the related cost is allowable and can be included in determination of the payment.

Covered RHC and FQHC services are set forth in K.A.R. 30-5-82, K.A.R. 30-5-118, and 42 CFR Part 405. These are as follows:

- Professional services furnished by clinic/center practitioners
- Services and supplies "incident to" a practitioner's services

8400. Updated 01/18

Examples of covered services:

- Dental (only for FQHCs that provide dental services)
- Family planning
- Mental health
- Newborn home visit
- Nursing for KBH-EPSDT only
- Obstetrical care
- Sexually transmitted diseases

RHC and FQHC services are covered for both Medicaid and MediKan beneficiaries.

A “covered *service*” is not necessarily a “covered *visit*.” It can be billed as a “covered visit” only when the service is rendered by a qualified practitioner and it is not content of service.

Content of Service

Content of service is a covered service or supply which is not a professional service by itself but is medically necessary and reasonable as part of a covered RHC/FQHC service provided by a practitioner. The cost associated with content of service is part of the clinic/center’s all-inclusive rate calculation. It should not be billed as an RHC/FQHC encounter or as a service under any other Medicaid provider number. Some examples of content of service include the following:

- “Incident to” services and supplies
Note: Those services of the clinic/center health care staff (such as a nurse or a therapist) and supplies (such as tongue depressor, bandage, thermometer) that must be an integral, although incidental, part of the rendition of a practitioner’s personal professional services in the course of diagnosis or treatment of an injury or illness. To be covered as “incident to,” a service or supply must be:
 - Furnished by a member of the clinic/center’s health care staff who is an employee of the clinic or center
 - Rendered under direct, personal, medical (not administrative) supervision of a physician
 - Of a type commonly furnished in a physician’s office without separate charge, performed away from the clinic/center facility only when accompanying a practitioner
- Professional component of radiology and EKG if performed by a clinic/center practitioner
- Drugs and biologicals that are not usually self-administered
- Administration of vaccine, immunization, or other injection
Note: It is requested that vaccines covered by the Vaccines for Children (VFC) program be billed for data collection purposes even though they are not reimbursable.

Global Billing

Surgical procedures furnished in an RHC or FQHC by an RHC or FQHC practitioner are considered RHC or FQHC services. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, the charges for the procedure go on the claim with the visit. Global billing requirements do not apply to RHCs and FQHC providers. Surgical procedures furnished at locations other than an RHC or FQHCs may be subject to KMAP global billing requirements. If an RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHC and FQHC providers may bill for a visit during the global surgical period if

KANSAS MEDICAL ASSISTANCE PROGRAM
RHC/FQHC FEE-FOR-SERVICE PROVIDER MANUAL
BENEFITS & LIMITATIONS

8400. Updated 06/2020

Global Billing continued

the visit is for a service not included in the global billing package. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.

Services not included in the global surgical package are listed in the KMAP Professional provider manual, and include, but are not limited to: initial consultation by the surgeon to determine the need for major surgery; visits unrelated to the diagnosis for which the surgical procedure is performed (unless the visit occurs due to complications of the surgery); treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.

Limitations and Requirements

- Limitations that currently apply to covered services under the state plan, also apply when provided by RHCs/FQHCs.
- Other insurance is primary and must be billed first. Refer to Section 3100 of the *General TPL Payment Fee-for-Service Provider Manual*.
- Lock-in referrals are required for beneficiaries locked into Medicaid providers.
- RHC services require (unless otherwise specified) a referral from the beneficiary's primary care case manager (PCCM).
- Copayment is applicable.

Noncovered Services

Noncovered services are services and supplies, both direct and indirect, not related to patient care and not reasonable and necessary for the efficient delivery of health care services for diagnosis and treatment of clinic/center patients.

- Services furnished by auxiliary health care staff who are not employed by the clinic or center
 - Services provided by auxiliary health care employees at the facility without direct supervision of a clinic or center practitioner
 - Services furnished by auxiliary health care employees away from the clinic/center facility when the employee goes to the site alone, without a clinic/center practitioner
 - Technical components of radiology and EKG
 - Clinical diagnostic laboratory services including the six required lab tests for RHC certification
 - Health care services performed by outside entities, including those owned by the center's owner(s) or staff
- Note:* The State Plan requires that providers of these services bill Medicaid directly.
- Drugs and biologicals which can be self-administered, such as oral prescription drugs or insulin injections

Dental Services (FQHCs only)

FQHCs providing dental services should bill these on the dental claim form using ADA procedure codes. Please refer to the *Dental Provider Manual* for covered services and other information.

Fluoride Applications (RHCs, FQHCs without a dental clinic)

Physicians (general practitioners, pediatricians, and family practice physicians), nurse practitioners, and physician assistants can provide a topical application of fluoride for TXIX- and TXXI-eligible

8400. Updated 01/2021

children. This service is limited to three applications per beneficiary per **calendar year**. The fluoride application must take place during a “billable encounter”.

Family Planning

The initial family planning visit is limited to one per beneficiary per lifetime. An annual family planning visit is limited to one every 12 months. Interim family planning visits are limited to 3 every 12 months.

Long-Acting Reversible Contraceptives

Effective with dates of service on and after February 27, 2018, long-acting reversible contraceptives (LARCs), both intrauterine devices (IUDs) and implants, are no longer included in the Prospective Payment System (PPS) rate. The following codes must be billed using the individual Medicaid provider number rather than the RHC/FQHC number and will be reimbursed on a fee-for-service (FFS) basis.

- J7297 for Liletta®
- J7301 for Skyla®
- J7298 for Mirena®
- J7296 for Kyleena®
- J7307 for Nexplanon®
- J7300 for ParaGard® T380A

Place of service (POS) code 11 (Office) should be used when billing for the LARC. Insertion for the device should be billed using the RHC/FQHC provider number. Providers continue to be reimbursed their encounter rate for insertion of the LARC.

Effective with dates of service on and after January 1, 2021, Maternal Depression screenings are reimbursable for Early Child Intervention services using the Current Procedural Technology (CPT) and Health Care Common Procedure Coding System (HCPCS) 96161, G8431 and G8510 when using one or more of the following validated screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screening Scale (PDSS)
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory II (BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Zung Self-Rating Depression Scale (SDS)

Approved Provider Type/Provider Specialty Code:
08-183 (Clinic-Early Intervention Services)

Approved Place of Service Codes:
11 (Office)
12 (Home)

8400. Updated 01/2021

A screening that occurs after the child is born is considered an Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit per Centers for Medicare and Medicaid Services (CMS) guidance, and should be billed under the infant's Medicaid ID number, using CPT code 96161. If the child does not have an assigned Medicaid ID number, CPT code 96161 can be billed under the mother's Medicaid ID number,

for up to 45 days postpartum. The screening CPT code 96161 is reimbursable up to five times postpartum, up until the child is 12 months of age.

The Maternal Depression Screenings can be administered by non-licensed staff. This includes home visitors, medical assistants, and community health workers since they are supervised by licensed professionals performing the primary service. These screenings should be reviewed by licensed professionals to ensure accuracy of the scoring and any necessary follow-up.

Referral and Follow-up Process on Positive Screenings Recommended by the American Academy of Pediatrics (AAP):

Immediate action is necessary if:

- Possible suicidality indicated in screening tool
- Mother expresses concern about her or her infant's safety
- Provider suspects that the mother is suicidal, homicidal, severely depressed, manic or psychotic

When a depression screen is positive, management varies according to the degree of concern and need.

Management of Postpartum Depression includes:

- Demystification (reducing guilt and shame by emphasizing how common these feelings are);
- Support resources (family and community); and
- Referrals for the mother (to a mental health professional or the mother's PCP or obstetrician), for the mother-infant dyad, for the child (for targeted promotion of social-emotional development and early intervention, and for the mother who is breastfeeding (for lactation support from an experienced provider).

Training Opportunities:

Optional training will be offered to screeners, including medical providers and their clinical staff, to increase timely detection of maternal depression.

The Mental Health Integration Toolkit on the KDHE website, will be updated by Public Health and will provide guidance on screening practices and patient and provider resources. There is also a national program, Mental Health First Aid, that teaches the skills to respond to the signs of mental illness and substance use.

Transcervical Sterilizations

- Procedure code 58579 is not covered for transcervical sterilization procedures. Procedure codes 58565, 0567T, and 0568T should ~~are to~~ be used. The procedure must meet all sterilization requirements. Prior authorization (PA) is required.
- The Essure Kit is included in procedure codes 58565, 0567T, and 0568T and should not be billed separately. The invoice does not need to be attached to the claim.
- If a beneficiary has had a transcervical hysteroscopy sterilization, a federal Consent for Sterilization form is required on and after October 1, 2015. Additionally, three months must have passed before performing code 58340. For dates of service prior to October 1, 2015, ICD-9 CM

8400. Updated 11/18

diagnosis code V252 must be used to indicate proof of sterilization. For dates of service on and after October 1, 2015, ICD-10 CM diagnosis code Z302 must be used. Prior authorization is not required.

Mental Health Services

Reference the *Mental Health Provider Manual* on the [Provider Manuals](#) page of the KMAP website for additional information.

Newborn Home Visit

The newborn visit in a beneficiary's home must be provided by a clinic/center practitioner. It is limited to one visit per newborn, 1 to 28 days after birth. A home visit by auxiliary staff without a practitioner is noncovered.

A newborn home visit consists of the following:

- Maternal assessment
- Newborn assessment
- Parenting and home assessment
- Education

A PCCM referral is not required to provide this service.

Note: Effective with dates of service on and after June 1, 2020, midwives may bill for newborn home visits. Providers must ensure the codes are covered by KMAP.

Obstetrical Services

No "bundled" codes are allowed for RHC/FQHC billing under KMAP. Traditionally "bundled" obstetrical (OB) services, such as routine OB care, should be "unbundled" and billed separately on per encounter basis. Prenatal visits and postnatal visits can be billed by the clinic/center using the appropriate *CPT*[®] codes, whereas other unbundled components of "bundled" services should not be billed under the RHC/FQHC provider number unless the services are furnished in an "approved" setting (see Place of Service criteria). When furnished in a nonapproved setting, such as a hospital, these services can be billed under the practitioner's provider number using separate CPT codes for unbundled services. Global codes (such as 59400 or 59510) should not be used when unbundled portions of traditionally bundled services are billed under more than one Medicaid provider.

OB global billing claims with a TPL paid amount

RHC/FQHCs billing global OB codes with TPL require a manual process for payment. These claims are to be sent to the Provider Relations/Written department of the fiscal agent with the following documentation:

- All associated claim forms related to delivery including postpartum and antepartum visits (procedure codes 59400-59622)
- The dates of service (listed for each visit and procedure code)
- The performing provider number
- Any other pertinent supporting documentation

When the claim is complete with all the necessary information, it will be forwarded to KDHE-DHCF for manual calculation and lump sum off system payment.

8400. Updated 11/18

Send the claims to:

Office of the Fiscal Agent
Provider Relations/Written Department
PO Box 3571
Topeka, Kansas 66601-3571

Telemedicine

Telemedicine is the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers.

Office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided through telecommunication technology. The consulting or expert provider at the distant site must bill an appropriate code from the list below with place of service (POS) 02 - Telemedicine and will be reimbursed at the same rate as face-to-face services. The originating site, with the beneficiary present, may bill code Q3014 with POS code 50 or 72 under the originating site provider ID and location number.

Note: As a reminder, the GT modifier is no longer required when billing for telemedicine services.

90785	90791	90792	90832	90833	90834	90836	90837	90838
90839	90840	90847	90863	90951	90952	90954	90955	90957
90958	90960	90961	92227	92228	96150	96151	96152	96153
96154	97802	97803	99201	99202	99203	99204	99205	99211
99212	99213	99214	99215	99304	99305	99306	99307	99308
99309	99310	99354	99355	99366	99367	99368	99406	99407
99495	99496	G0406	G0407	G0408	G0425	G0426	G0427	G0508
G0509	H0031HO	H0032HA						

KMAP does not recognize the following AMA CPT consultation codes for payment:

99241	99242	99243	99244	99245	99251	99252	99253	99254	99255
-------	-------	-------	-------	-------	-------	-------	-------	-------	-------

Providers who are not RHC or FQHC providers and are acting as the distant site will be reimbursed in accordance with a percentage of the Physician Fee Schedule and not an encounter rate.

Limitations

- The beneficiary must be present at the originating site.
- Email, telephone, and facsimile transmissions are not covered as telemedicine services.
- Documentation requirements are the same as face-to-face services.

Screening, Brief Intervention, and Referral for Treatment

- Screening, Brief Intervention, and Referral for Treatment (SBIRT) is an evidence-based approach for identifying patients who use alcohol and other substances at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents, and injuries. SBIRT is designed to identify an individual who has an alcohol and/or other substance use disorder or is at risk for developing one by evaluating responses to questions about alcohol and/or other substance use.

8400. Updated 07/15

- Practitioners providing SBIRT services to Medicaid-eligible patients in Kansas must meet the applicable KDADS requirements including the following:
 - Currently licensed and in good standing as an approved professional type
 - Submission of an attestation (facility) or certificate (individual) as proof of completion of an approved SBIRT training
- Services to patients must be provided in an approved service location.
- Reference the *Substance Use Disorder Provider Manual* on the [Provider Manuals](#) page of the KMAP website for additional information on practitioner, facility, code, billing, and documentation requirements.
- More information on SBIRT can be found on the [SBIRT](#) page of the SAMHSA website or the [Policies and Regulations](#) page of the KDADS website.

Visiting Nurse Services

Part-time or intermittent nursing care provided in a patient's place of residence may be billed as an encounter if all the following apply:

- The clinic/center is located in an area designated as an area with a shortage of Home Health Agencies.
- The services are rendered to a homebound patient who is confined to his or her place of residence.
- The "place of residence" is NOT a hospital, long-term facility, or SNF.
- The services are furnished by an RN or LPN who is employed by or receives compensation from the RHC/FQHC.
- The services are furnished under a written plan of treatment reviewed at least every 60 days.
- The services consist of nursing care performed by an RN or LPN. This does not include housekeeping services.

Commingling

Commingling is the blending of RHC's or FQHC's operations with another entity or entities, such as a physician's practice, lab, etc., with commensurate sharing of space, staff, supplies, and other resources. They may or may not be located in the same building. A defined physical area, hours of operation, each practitioner's and staff's time, and other resources devoted only to RHC or FQHC operation should be set aside in advance and distinguished from other entities.

This separation must be maintained at all times while performing day-to-day functions and reflected in all RHC/FQHC records, bills submitted for services rendered, and cost reports. Examples of the separation of RHC/FQHC operations from other related entities include:

- RHC/FQHC practitioners and auxiliary staff (both medical and administrative/overhead) should not simultaneously provide services to the RHC/FQHC and other entities.
- Different staff, or different hours of the same (common) staff, must be scheduled for conducting clinic/center business and that of other entities.
- During the time a practitioner is scheduled to work for other entities (such as a private practice), his or her services must NOT be billed under the RHC/FQHC provider number.
- During the time a practitioner is scheduled to work for the RHC/FQHC and his or her time is being charged to the clinic/center, he or she should not treat patients that are not clinic/center patients. The services rendered to clinic/center patients

8400. Updated 07/15

during this time should only be billed under the RHC/FQHC provider number.

- If an RHC/FQHC and other entities share supplies, equipment, or other resources, the cost attributable to each entity must be determined using a logical basis (such as square footage for building related costs, charge sheets with actual usage for medical supply cost, etc.) and distinguished in the facility records. At the time of cost reporting, either just the clinic/center's portion should be reported on the RHC/FQHC cost report, or if the entire cost of the shared resource is included on the RHC/FQHC cost report, the portion attributable to other entities should be carved out.
- 42 CFR 491.10 requires RHCs and FQHCs to maintain records for each patient which include specific personal and medical information. RHC/FQHC patient records must be separate from other entities' patient records.

Reimbursement

KMAP has established the PPS for RHCs and FQHCs mandated by the Benefits Improvement and Protection Act (BIPA) of 2000.

- **Prospective Payment System (PPS)**
Under this methodology, clinics/centers are paid prospective rates based on an average of the reasonable costs for the two base years with no retroactive cost settlements.
- **Change in scope of services**
If an RHC or FQHC expects a change in the scope of covered services, a written description of the proposed change with budgeted increase or decrease in cost and total number of visits should be submitted to the State. An adjustment to the rate may be made based on a review of the submitted information.

Rate Setting

Reasonable Cost

Reasonable cost consists of necessary and proper cost incurred in providing covered services to all clinic/center patients. Reasonable cost and adjusted total visits are derived from the cost report by applying cost reimbursement principles, productivity screens, and other tests of reasonableness and coverage criteria set forth in K.A.R. 30-5-118, 118a and 118b; 42 CFR Part 405; 42 CFR Part 413; Medicare Publication 27; and Medicaid state plan.

Initial Rate for Newly Enrolled Providers

- **Provider already established as RHC or FQHC before Medicaid enrollment -**
PPS baseline rate will be derived from finalized Medicare cost reports covering the two most recent fiscal years.
- **Newly certified RHC/FQHC -** The average of the rates paid to other similar RHC/FQHCs in the area will be used.

Base Years

Under BIPA, a clinic/center's PPS rate is derived from two base years.

- For providers enrolled before January 1, 2001, the base years are facility fiscal years 1999 and 2000.
- For new providers that are already established RHCs or FQHCs at the time of enrollment, base years are the two most recent facility fiscal years.
- For clinics or centers newly certified as RHCs or FQHCs, base years are the two fiscal years following the first year in business as an RHC or FQHC.

8400. Updated 07/15

PPS Rate Determination

PPS rate is an average of the rates from the two base years. Each base year's rate for an RHC is the Medicare rate obtained from the finalized Medicare cost report. Each base year's rate for an FQHC is computed by Medicaid from reasonable costs and adjusted total visits derived from the cost report.

PPS Baseline Rate

Baseline rate is the PPS rate derived from an RHC's or FQHC's base years:

- **Providers enrolled before January 1, 2001** – It will be effective January 1, 2001, to September 30, 2001.
- **New providers** – It will be effective from the enrollment date through the following September 30.

Rate Change

Effective October 1 each year, the existing payment rate will be changed by the percent change in Medicare Economic Index (MEI) for primary care services.

Cost Reports

RHCs are required to submit cost reports to Medicaid. The Department uses finalized Medicare cost reports. For freestanding RHCs, *RHC* cost reports received from the Medicare intermediary for independent RHCs are used. For provider-based RHCs, *hospital* cost reports received from the Medicare intermediary for hospitals are used.

Each FQHC is required to submit the same cost report as the one filed with Medicare on the most recent version of Form HCFA-222-92 (Rev. July 1994) within five months after the fiscal year end. The only differences between Medicare and Medicaid cost reports are dentist visits and KBH-EPSTD nursing assessments which are not recognized by Medicare. A productivity standard of 2,100 should be used for reporting dentist visits. The cost report should be supplemented by the information listed below and all other supporting documents must be available for review:

- A detailed trial balance which includes cost report line numbers for cross-checking
- Independent auditor's report and management letter
- An itemized list of revenue including source and purpose
- Any additional information necessary to facilitate reconciliation of reported expenditures with the trial balance and financial statements

Managed Care Entity Contracts

MCOs must reimburse providers using the PPS rate. PPS rates will be re-evaluated at least every five years.

Other Ambulatory Services

"Other ambulatory services" are those services which do not meet the Medicare definition of core services under RHC and FQHC benefits and preventive services under FQHC benefit but are covered under the Medicaid state plan. Some examples are ambulance, durable medical equipment, prescription drugs, occupational therapy, physical therapy, and technical components of radiology or EKG. KMAP reimburses for "other ambulatory services" (excluding dental services for FQHCs) furnished by RHCs and FQHCs using the methodologies utilized in paying for same services in other settings. To receive reimbursement for "other ambulatory services," requirements under the state plan must be met, including enrollment under the respective provider type. These services should be billed under the performing provider's individual Medicaid provider number.

