

# Federally Qualified Health Centers Table of Contents

**John R. Kasich, Governor**

**John B. McCarthy, Director**

## Ohio Department of Medicaid

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# Medicaid Handbook Transmittal Letters

# MHTL 3354-12-01 (Adoption of Rule 5101:3-28-08.1 to Establish an APM for Government-Operated FQHCs)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3354-12-01

September 27, 2012

TO: Eligible Federally Qualified Health Center Providers  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medical Assistance

SUBJECT: Adoption of Rule 5101:3-28-08.1 to Establish an Alternate Payment Method (APM) for Government-Operated Federally Qualified Health Centers (FQHCs)

New rule [5101:3-28-08.1](#), titled "Federally qualified health center (FQHC): alternate payment method (APM)," is being adopted to establish a method of additional payment for services rendered by an FQHC that is operated by a state or local governmental entity (a "government-operated FQHC"). Under the APM, if the actual cost a government-operated FQHC incurs in providing services to Medicaid-eligible individuals is greater than the aggregate reimbursements it receives under the FQHC prospective payment system (PPS), then the difference may be counted as a Medicaid expenditure for which the government-operated FQHC then receives Federal matching funds.

### Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

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### Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516



# MHTL 3354-09-03 (Addition of H1N1 Pandemic Influenza Vaccine to Immunizations Rule)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3354-09-03

January 22, 2010

TO: All Eligible Federally Qualified Health Centers  
FROM: Douglas E. Lumpkin, Director  
SUBJECT: Addition of H1N1 Pandemic Influenza Vaccine to Immunizations Rule

This letter provides information regarding changes to Ohio Administrative Code (OAC) rule [5101:3-4-12](#) Immunizations.

Rule 5101:3-4-12 Rule 5101:3-4-12 specifies immunizations that are covered for the Medicaid population. The rule is being proposed for amendment to include the Current Procedural Technology (CPT) code 90663 (Influenza virus vaccine, pandemic formulation) to the list of designated free vaccines so that providers may bill for immunizations against the pandemic influenza virus, H1N1. The Department will reimburse \$10 for the administration of each dose of this vaccine needed for both children and adults. The rule also specifies how Medicaid providers can obtain the pandemic influenza vaccine free of charge from the Ohio Department of Health. It is also being modified for five-year rule review, to update date references and to clarify existing policy.

### Web Page:

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Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
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Office of Ohio Health Plans  
Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

## **MHTL 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01)**

**Medicaid Handbook Transmittal Letter (MHTL) [No. 3334-09-02](#)** is maintained in the General Information e-book.

# **MHTL 3354-09-02 (Pregnancy Prevention/Contraceptive Management Services [Family Planning])**

## **Medicaid Handbook Transmittal Letter (MHTL) No. 3354-09-02**

July 10, 2009

**TO:** All Eligible Federally Qualified Health Center Providers  
Directors, County Departments of Job and Family Services

**FROM:** Douglas E. Lumpkin, Director

**SUBJECT:** Pregnancy Prevention/Contraceptive Management Services (Family Planning)

This letter provides information regarding the rescission, amendment, and issuance of Ohio Administrative Code (OAC) rules related to pregnancy prevention and contraceptive management services ("family planning services").

Important elements of these rules include:

1. Family planning means preventing or delaying pregnancy.
2. Family planning services means pregnancy prevention/contraceptive management services.
3. Family planning services are not subject to a co-payment, regardless of gender.
4. Infertility services are not Medicaid covered.
5. Hysterectomies and voluntary sterilizations are Medicaid covered services.
6. Providers must include valid Medicaid-covered CPT and/or HCPCS procedure codes and a valid contraceptive management diagnosis code (V25.0 through V25.9) on claims for pregnancy prevention/contraception services.

OAC rule 5101:3-1-09 is titled "Medicaid co-payment program [except for Medicaid consumers enrolled in the Medicaid managed health care program]." This rule establishes co-payment requirements for Medicaid consumers. Paragraph (C)(5) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and that these services are not subject to a co-payment, regardless of gender. This rule is also amended to update a rule reference and correct grammatical errors.

OAC rule 5101:3-4-02 is titled "Scope of coverage." This rule establishes the requirements of physician supervision of services provided by nonphysicians. Paragraph (D)(2)(d) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update rule references, improve sentence structure, delete an out of date reference to registered nurses, and include a reference to occupational therapists.

OAC rule 5101:3-4-07 is titled "Family planning services." This rule is rescinded and replaced with rules 5101:3-21-02, 5101:3-21-02.1, and 5101:3-21-02.2.

OAC rule 5101:3-4-13 is titled "Therapeutic injections (including trigger point injections) and prescribed drugs." This rule sets forth requirements related to Medicaid coverage of therapeutic injection services. Paragraph (A)(3)(a)(iii) of this rule is amended to clarify that infertility treatment services are not Medicaid covered.

OAC rule 5101:3-4-28 is titled "Noncovered services." This rule describes services that are not covered by Medicaid. Paragraphs (E) and (F) are removed to clarify that hysterectomies and voluntary sterilizations are Medicaid covered services. Paragraphs (G) and (H) are amended to clarify that infertility treatment services are not Medicaid covered. This rule is also amended to remove redundant language and to update a rule reference.

OAC rule 5101:3-4-34 is titled "Preventive medicine services." This rule defines preventive medicine as services that prevent disease, maintain good health, and proactively avoid disease, disability and death. This rule specifies which preventive medicine services are covered under the Ohio Medicaid program. Paragraph (B)(4) of this rule is amended to clarify that family planning services means pregnancy

prevention/contraceptive management services. This rule is also amended to update rule references and correct formatting errors.

OAC rule 5101:3-13-01.5 is titled "Fee-for-service ambulatory health care clinics (AHCCs): family planning clinics." This rule outlines requirements that apply to all fee-for-service family planning AHCCs. This rule is amended to clarify definitions in paragraph (A) and to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update a rule reference.

OAC rule 5101:3-21-01 is titled "Sterilization." This rule sets forth requirements regarding Medicaid coverage of permanent sterilization and hysterectomy procedures. This rule is rescinded and replaced with new rule 5101:3-21-02.2, "Medicaid covered reproductive health services: permanent contraception/sterilization services."

OAC rule 5101:3-21-01 is titled "Medicaid covered reproductive health services: preconception care services." This new rule describes Medicaid coverage of services that are provided for the primary purpose of achieving optimal outcome of future pregnancies.

OAC rule 5101:3-21-02 is titled "Medicaid covered reproductive health services: pregnancy prevention/contraception services overview." This new rule replaces, in part, rescinded rule 5101:3-4-07 and describes Medicaid coverage of services that are provided for the primary purpose of pregnancy prevention/contraceptive management.

OAC rule 5101:3-21-02.1 is titled "Medicaid covered reproductive health services: temporary pregnancy prevention/contraception services." This new rule replaces, in part, rescinded rule 5101:3-4-07 and describes Medicaid coverage of services provided for the primary purpose of temporary pregnancy prevention/contraceptive management.

OAC rule 5101:3-21-02.2 is titled "Medicaid covered reproductive health services: permanent contraception/sterilization services." This new rule replaces, in part, rescinded rule 5101:3-21-01 and in part, rescinded rule 5101:3-4-07. This new rule describes Medicaid coverage of services that are provided for the purpose of permanent pregnancy prevention/contraceptive management (sterilization).

OAC rule 5101:3-21-03 is titled "Medicaid covered reproductive health services: infertility services." This new rule describes Medicaid coverage of infertility services.

OAC rule 5101:3-29-01 is titled "Eligible providers." This rule describes Medicaid requirements pertaining to provider enrollment as an "outpatient health facility" (OHF). Paragraph (E) is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and that such services are considered preventive in nature. This rule is also amended to update a rule reference, correct spelling and grammatical errors, and incorporate terminology consistent with Chapter 5101:3-4 of the Administrative Code.

OAC rule 5101:3-29-04 is titled "Billable services." This rule specifies Medicaid requirements pertaining to services provided by outpatient health facilities. Paragraph (B) is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and to clarify that such services are considered preventive in nature. This rule is also amended to restructure paragraph (B)(1)(c) and correct spelling and grammatical errors.

These rules do not include detailed information regarding Medicaid coverage of pharmacy, durable medical equipment, and laboratory services as they relate to pregnancy prevention/contraceptive management services. Please refer to Chapters 5101:3-9, 5101:3-10, and 5101:3-11 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to these topics.

These rules do not include detailed information regarding Medicaid coverage of pregnancy prevention/contraceptive management services provided in hospitals. Please refer to Chapter 5101:3-2 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to facility providers.

These rules do not include detailed information regarding Medicaid coverage of pregnancy prevention/contraceptive management services provided under managed care. Please refer to Chapter 5101:3-26 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to Medicaid managed care.

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Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
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**Questions:**

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Office of Ohio Health Plans  
Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone 800-686-1516

# **MHTL 3354-09-01 (Physician Assistants)**

## **Medicaid Handbook Transmittal Letter (MHTL) 3354-09-01**

February 19, 2009

TO: All Eligible Federally Qualified Health Center Providers  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Physician Assistants

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rule 5101:3-4-02, "Scope of coverage" and the rescission and adoption of new OAC rule 5101:3-4-03, "Physician assistants."

OAC rule 5101:3-4-02 is titled "Scope of coverage." This amended rule outlines the requirements regarding physician supervision of non-physicians when non-physicians provide Medicaid reimbursable services. This rule is amended to incorporate changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This amended rule updates the reference to the required level of physician supervision of physician assistants so that such reference is consistent with proposed rule 5101:3-4-03, "Physician assistants," of the Administrative Code.

Specifically, this rule removes paragraph (C)(2)(c), which indicated that physician assistants must be "under the general supervision of the physician" in order for Medicaid to reimburse eligible providers for provision of physician assistant services. This amended rule includes a new reference, paragraph (D), to rule 5101:3-4-03 and Chapter 4730-1 of the Administrative Code, "Physician assistants." This referenced rule addresses the required level of physician supervision of physician assistants in order for Medicaid to reimburse eligible providers for provision of physician assistant services.

OAC rule 5101:3-4-03 is titled "Physician Assistants." This new rule incorporates changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This new rule explains the conditions under which Ohio Medicaid will reimburse Medicaid providers for physician assistant services.

This new rule:

- Provides new and updated definitions as well as definitions by reference;
- Provides updated references to the Section 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code that govern the practice of Physician Assistants in Ohio;
- Removes requirements that a patient new to a physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant;
- Removes requirements that an established patient with a new condition must be seen and personally evaluated by the supervising physician or prior to initiation of any treatment plan for that condition;
- Removes requirements that medical records for patients new to a physician's practice and medical records for established patients with a new condition must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant;
- Clarifies that Medicaid providers will not be reimbursed for visits provided on the same date of service by both a physician assistant and his/her supervising physician, employing physician, employing physician group practice, or employing clinic; and
- Clarifies that direct reimbursement is not available for services provided by a hospital employed physician assistant. The reimbursement for the services provided by the physician assistant is bundled into the facility payment made to the hospital.

This rule does not include information regarding Medicaid coverage of Pharmacy, Durable Medical Equipment, and Laboratory Services. Please refer to Chapters 5101:3-9, 5101:3-10, and 5101:3-11 of the Ohio Administrative Code for Ohio Medicaid requirements related to these topics.

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Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
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# Miscellaneous Medicaid Handbook Transmittal Letters

## **MHTL 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates)**

**Medicaid Handbook Transmittal Letter (MHTL) [No. 3334-10-02](#)** is maintained in the General Information e-book.

## **MHTL 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01)**

**Medicaid Handbook Transmittal Letter (MHTL) [No. 3334-09-02](#)** is maintained in the General Information e-book.

## **MHTL 3336-10-01 (Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule)**

**Medicaid Handbook Transmittal Letter (MHTL) [No. 3336-10-01](#)** is maintained in the Physician Services e-book.

# Medical Assistance Letters

## **MAL 583 (Medicaid Pharmacy Coverage for Dual Eligibles Effective January 1, 2013)**

**Medical Assistance Letter (MAL) [583](#)** is maintained in the Pharmacy Services e-book.

## **MAL 582 (Pharmacy Program Changes Effective October 1, 2012)**

**Medical Assistance Letter (MAL) [582](#)** is maintained in the Pharmacy Services e-book.

## **MAL 569 (Changes to the Medicaid Preferred Drug List Effective October 1, 2010)**

**Medical Assistance Letter (MAL) [569](#)** is maintained in the Pharmacy Services e-book.

## **MAL 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies)**

**Medical Assistance Letter [No 561](#)** is maintained in the Pharmacy Services e-book.

## **MAL 546 (March 20, 2008 - Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms)**

**Medical Assistance Letter [No 546](#)** is maintained in the Pharmacy Services e-book.

**MAL 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516)**

**Medical Assistance Letter [No 522](#)** is maintained in the General Information e-book.

## **MAL 516 (November 9, 2006- Employee Education About False Claims Recovery)**

**Medical Assistance Letter [No 516](#)** is maintained in the General Information e-book.

# MAL 511 (Information about the NPI)

## Medical Assistance Letter (MAL) 511

September 12, 2006

To: Federally Qualified Health Centers and Look-Alikes  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

From: Barbara E, Riley, Director

Re: Information about the National Provider Identifier (NPI)

In accordance with federal regulations (45 CFR § 160.103 and 45 CFR § 162.404), health care providers that conduct business in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) will be required to obtain a unique, ten-digit National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES). The deadline for providers to begin using their NPI to bill and receive payments electronically from Medicare and Medicaid is May 23, 2007. This MAL provides direction to FQHCs on how to enumerate through NPPES to ensure successful Medicaid billing and reimbursement in Ohio using the NPI.

FQHCs need to enumerate through NPPES prior to the May 23, 2007 deadline. To obtain a National Provider Identifier, FQHCs should contact NPPES directly at <http://nppes.cms.hhs.gov> or by phone at 1-800-465-3203 (1-800-692-2326 (TTY)). Providers can apply for an NPI electronically or by paper.

### I. Background: NPI Enumeration to Support Medicaid Reimbursement

#### Provider Type 12 - Prospective Payment FQHC Claims

FQHCs are required to obtain Medicaid provider numbers for sites as defined in Ohio Administrative Code rule 5101:3-28-04 (paragraph (B)(9)). The advent of the NPI enumeration process will not change this requirement, and new FQHCs will continue to be assigned a seven-digit Medicaid provider number upon enrollment. In the future, ODJFS will refer to the Medicaid provider number as the legacy number.

Site-specific NPI enumeration is critical to maintaining the current method of FQHC reimbursement. Currently, a prospective payment system (PPS) payment is made for each type of service delivered at each FQHC site. To maintain this method of reimbursement, each FQHC site must have and use a separate NPI number.

#### Provider Type 50 - Fee-for-Service Clinic Claims

Currently, FQHCs use a second Medicaid provider number to bill for non-PPS covered services. They bill as a type 50 fee-for-service clinic when they bill for the following:

1. Disability Medical Assistance claims;
2. Medicare crossover claims not paid through the automatic crossover process; and,
3. Inpatient hospital surgery, visits, or consultation claims.

**It will be necessary for each site to separately apply for and receive a second NPI number to continue to bill and be reimbursed for non-PPS services.**

### II. NPI Details

As described above, FQHC sites that have two Medicaid provider numbers will need to acquire two NPI numbers. One NPI number will be used to submit type 12 FQHC PPS claims; the other NPI number will be used to submit type 50 fee-for-service clinic claims.

FQHC sites can receive two different NPI numbers by submitting **two different applications** to NPPES using a different taxonomy code in each application. The taxonomy codes to use are

261QF0400X for FQHC (type 12) claims and 261QP2300X for fee-for-service (type 50) claims. (The latter taxonomy code refers to a Primary Care Clinic.) FQHCs should use the two taxonomy codes above in completing Section D of the NPI applications when asked for the "provider taxonomy code."

The requirement for an NPI number applies both to existing FQHC sites and to any FQHC enrolling for the first time. The Department has updated the Medicaid provider application to capture the ten-digit NPI number from new FQHCs enrolling for the first time. The NPI number should be submitted on page two of the provider application.

The NPI number can be used as soon as it is received. When billing ODJFS electronically, **the NPI number is used in conjunction with the Medicaid provider number.** (Instructions how follow below.) The NPI number must be used to adjudicate EDI claims on and after May 23, 2007.

#### Billing NPI on EDI Claims

The NPI number should be entered in the primary identifier field on ASCII X12 837 health care transactions. (Note: FQHCs are required to bill Ohio Medicaid on the 837 Professional (P) transaction.)

When submitting EDI claims with the NPI, FQHCs should use the qualifier XX in the primary identification qualifier location NM108 and the NPI in the primary identification location NM109. FQHCs should continue to submit their Medicaid provider number with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid provider number in the secondary identification location REF02 until May 23, 2007 as directed in the NPI Final rule. FQHCs will submit their provider identifiers in the 2010AA loop of the 837 P transaction. FQHCs are not required to send the rendering provider loop in the 837. If a rendering provider loop 2310B is submitted in the 837, errors in reimbursement will occur.

#### Billing on Paper Claims or by Tape

FQHCs should continue to use their Medicaid provider number when submitting claims in formats that use only the Medicaid provider number, e.g., the current CMS 1500 paper claim.

### **III. Changes in Crossover Claims Processing**

Medicaid is working on being able to receive Medicare crossover claims automatically from the fiscal intermediary used by FQHCs, e.g., United Government Services. When this happens, crossover claims will be processed using the type 12 FQHC provider number. To avoid the possibility of duplicate claims payment, FQHCs should check to determine whether payment has already been made under the type 12 FQHC provider number before submitting crossover claims using the type 50 fee-for-service clinic number. The claim may have already crossed over to ODJFS and been paid.

ODJFS appreciates the attention of the FQHCs in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

#### Requesting Paper Updates

If a provider does not have internet access and wishes to request a paper copy of FQHC rule 5101:3-28-04, the provider should complete the attached JFS 03400 and either mail it or fax it to the address on the form.

**Questions pertaining to this MAL should be addressed to:**

**Bureau of Plan Operations**

**The Provider Network Management Section**

**P.O. Box 1461**

**Columbus, Ohio 43216-1461**

**Toll free telephone number 1-800-686-1516**

# **MAL 508 (Federally Qualified Health Centers Policy/Rule Updates)**

## **Medical Assistance Letter MAL 508**

July 12, 2006

TO: All Eligible Providers of Federally Qualified Health Center (FQHC) Services  
Directors, County Department of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Federally Qualified Health Centers Policy/Rule Updates

### **EFFECTIVE July 1, 2006**

The purpose of this Medical Assistance Letter (MAL) is to announce updates to the rules governing FQHCs and to provide reminders regarding existing policy. Note: The rules relating to these policy changes are scheduled to be effective for dates of service on or after July 1, 2006, pending approval by the Centers for Medicare and Medicaid Services (CMS).

Rules 5101:3-28-01, 5101:3-28-02, 5101:3-28-03, 5101:3-28-04, 5101:3-28-07, 5101:3-28-08, 5101:3-28-09, 5101:3-28-10 and 5101:3-28-11 of the Ohio Administrative Code (OAC) are amended to fulfill five year rule review requirements.

The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Federally Qualified Health Centers handbook. The Department encourages providers to visit the website and review the full text of the amended FQHC provider rules.

Key points of interest in the amended rules are:

- New language is added to address coverage of up to two FQHC denture follow-up visits and consumer co-payment for certain types of services.
- New language is added to address coverage up to two FQHC denture follow-up visits and claims submission requirements for FQHCs in managed care settings.
- Adding a reference to claims submission requirements for FQHCs in managed care settings.

Rule 5101:3-28-01, "Federally qualified health centers (FQHCs): eligibility and enrollment as a medicaid provider."

This rule defines "Federally Qualified Health Center" for the purposes of Medicaid reimbursement. This amended rule provides clarification regarding the status of FQHC look-alikes for Medicaid purposes; the required documentation of FQHC status that an FQHC must provide to the department; that newly enrolled FQHC providers cannot simultaneously be enrolled as rural health clinic Medicaid provider or as an outpatient health facility Medicaid provider.

Rule 5101:3-28-02, "Federally qualified health centers (FQHCs): covered services."

This rule defines covered FQHC services, "covered core services" and "covered noncore services" for the purposes of Medicaid reimbursement. This rule provides clarification regarding visiting nurse services, mental health services, and billing of non-FQHC services by an FQHC.

Rule 5101:3-28-03, "Federally qualified health centers (FQHCs): coverage and limitation policies."

This rule defines the coverage and limitations of FQHC services, "covered core services" and "covered noncore services" for the purposes of Medicaid reimbursement. This rule provides clarification regarding advanced practice nurses, limitations of covered noncore services, and mental health services. New language is added to address coverage of up to two FQHC denture follow-up visits and consumer co-payment for certain types of services.

Rule 5101:3-28-04, "Federally qualified health centers (FQHCs): billable services."

This rule defines billable FQHC services for the purposes of Medicaid reimbursement. This rule provides clarification regarding the policy that each FQHC service site must have its own Medicaid provider number. New language is added to address coverage up to two FQHC denture follow-up visits and claims submission requirements for FQHCs in managed care settings.

5101:3-28-07, "Federally qualified health centers (FQHCs): supplemental payments."

This rule defines "supplemental payments" for the purposes of Medicaid reimbursement when an FQHC has received payment from a Medicaid managed care plan for FQHC services. This rule provides clarification by striking language referencing the process for providing supplemental payments for the service provided during the first half of 2001 and by striking references to invalid local level codes.

Rule 5101:3-28-08, "Federally qualified health centers (FQHCs): general provisions of the prospective payment system (PPS)."

This rule defines PPS for the purposes of Medicaid reimbursement. This rule provides clarification by relocating definitions to rule 5101:3-28-09, by removing references to phase one of the Medicaid PPS system, by adding language to state that each FQHC service site must have its own PPS rates, and by removing references to rule 5101:3-28-05, which was previously rescinded.

Rule 5101:3-28-09, "Federally qualified health centers (FQHCs): prospective payment system (PPS) rate review for change in scope of service."

This rule defines the two methods for determining PPS rates for a change in scope of service for the purposes of Medicaid reimbursement. This rule provides clarification by relocating definitions from rule 5101:3-28-08, specifying that only one cost report is needed under method one, specifying that two cost reports are needed under method two and updating language regarding transportation service.

Rule 5101:3-28-10, "Federally qualified health centers (FQHCs): prospective payment system cost report."

This rule defines the filing requirements for cost reports. This rule provides clarification by restructuring paragraph (B) to provide information in parallel to paragraph (A) and include more detailed information about the filing requirements.

Rule 5101:3-28-11, "Federally qualified health centers (FQHCs): billing for FQHC services."

This rule defines the billing process for FQHCs. This rule provides clarification by removing references to the ODJFS electronic manuals, and adding a reference to claims submission requirements for FQHCs in managed care settings.

### **Web Page Distribution:**

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this MAL, and any attachments, may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Federally Qualified Health Center Services Handbook."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired MAL number.
- (4) Scroll through the MAL to the desired rule number highlighted in blue and select the rule number.

### **Requesting Paper Updates:**

If a provider does not have access to the internet and wishes to request a paper copy of updates to the FQHC rules, please complete the attached JFS 03400 and either mail it or fax it to the address on the form.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

# **MAL 503 (Ohio Medicaid Coverage of Fluoride Varnish Application by Non-Dental Providers)**

## **Medical Assistance Letter (MAL) No. 503**

July 14, 2006

To: Federally Qualified Health Centers (FQHC)  
Rural Health Clinics (RHC)  
Outpatient Health Facilities (OHF)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Re: Ohio Medicaid coverage of fluoride varnish application by non-dental providers

The purpose of MAL No. 503 is to inform providers of physician services of the coverage and limitation of OAC rule 5101:3-4-33 Coverage of fluoride varnish by non-dental providers.

This new physician services rule, effective July 1, 2006, authorizes Medicaid program coverage and separate reimbursement for eligible providers of physician services to perform fluoride treatment, within their scope of practice, through the application of fluoride varnish during the course of a well or sick child examination for children to age three when medically appropriate. Coverage of fluoride treatments by physician providers is limited to one application every one hundred eighty days.

Fluoride varnish can arrest demineralization and remineralize teeth damaged by the decay process. The application of fluoride varnish has three components each of which must be performed: oral assessment, varnish application and referral.

In addition to the oral assessment and varnish application, parents or guardians must be provided with information about the fluoride varnish procedure and proper oral health care for their child. If the child has obvious oral health problems and does not have a dental provider, he/she must be referred to a dentist or the county department of job and family services.

In order to be reimbursed for the professional services associated with the application of fluoride varnish, clinics should follow their standard billing procedures. Cost-based clinics (e.g. Federally Qualified Health Centers, Outpatient Health Facilities, Rural Health Clinics) must submit code T1015 with the appropriate two digit modifier in addition to CDT code D1203 (topical application of fluoride (prophylaxis not included) - child).

Cost-based clinics cannot bill the application of fluoride varnish as a separate encounter. Cost-based clinics that provide dental services must bill fluoride varnish as part of a dental encounter as they currently do. Cost-based clinics that do not provide dental services must bill fluoride varnish as part of a medical encounter. T1015 U1 (medical) cannot be billed twice on the same date of service related to the provision of fluoride varnish (once for the visit and a second for the application of fluoride varnish)

The appropriate modifiers for a medical or dental encounter are:

FQHC: U1 (medical encounter), U2 (dental encounter)

OHF: U1 (medical encounter), U2 (dental encounter)

RHF: U1

Provider handbooks, billing instructions and other provider communications are available on the Department's electronic manual site at:

<http://emanuals.odjfs.state.oh.us/emanuals>

If you do not have internet access, you may request a paper copy of the new OAC rule 5101:3-10-33 Coverage of fluoride varnish by non-dental providers mentioned in this MAL by completing and returning the attached form JFS 03400.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

# **MAL 488 (Unique Medicaid Provider Number for Each Service Site)**

## **Medical Assistance Letter (MAL) No. 488**

October 3, 2005

TO: Federally Qualified Health Centers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Unique Medicaid Provider Number for Each Service Site

The purpose of this Medical Assistance Letter (MAL) is to clarify the existing requirement that each Federally Qualified Health Center (FQHC) obtain and utilize a unique Medicaid provider number for each service site approved by the Health Resources and Services Administration (HRSA) to provide FQHC services. Each HRSA-approved FQHC service site must also obtain its own PPS rate for each HRSA approved type of service provided at that service site. For the purposes of Ohio Medicaid, an FQHC service site is a service site approved by HRSA and identified in the HRSA Notice of Grant Award.

### Policy Clarifications: Billable Services

Covered services for FQHCs are identified in rule 5101:3-28-02 of the Administrative Code and must be provided in accordance with Chapter 5101:3-28 of the Administrative Code.

- Each FQHC service site must obtain a unique Medicaid provider number and use that provider number to bill for all encounters at the service site. Services provided by use of a mobile unit, such as dental services provided by van, must be associated with a specific HRSA-approved FQHC site under the terms and conditions specified in the HRSA Notice of Grant Award and must be billed using the provider number of the HRSA approved site held accountable for the delivery of the services.
- Each FQHC service site must obtain its own PPS rate for each HRSA-approved type of service provided at the service site. An FQHC service site may not use the provider number of another service site to bill Medicaid.
- FQHC services are billed on an encounter basis. Encounters may be billed only for services provided at an FQHC service site approved by HRSA, in accordance with rule 5101:3-28-04 of the Administrative Code.

### Obtaining a provider number and rate: New FQHC site:

Any new FQHC service site must complete a provider application that can be found on the department's web site at <http://ifs.ohio.gov/ohp/provider.stm>. As part of the application, the FQHC service site must provide appropriate documentation that the service site provides services in accordance with the provisions of sections 329, 330, or 340 of the Public Health Services Act. The service site must be identified in the notice of grant award submitted with the application.

After receiving a Medicaid provider number from the Provider Enrollment section in the Medicaid Bureau of Plan Operations, the FQHC must request a PPS rate for each type of service provided at that site by contacting the Financial Management Unit of the Bureau of Health Plan Policy at 614-466-6420. The request must include a listing of the type(s) of service that the FQHC site plans to provide and must include a copy of the letter from the Provider Enrollment section that lists the new Medicaid provider number for the FQHC site. The Financial Management Unit will send a letter to the FQHC listing the start-up rate(s) for the new FQHC service site. Rule 5101:3-28-08 of the Administrative Code describes how the start-up rate for a new FQHC is established.

### Obtaining a rate: Existing FQHC service site wishing to add a new type of service:

Any existing FQHC service site that adds a new type of service must notify the Financial Management Unit of the Bureau of Health Plan Policy in writing that the existing FQHC plans to add a HRSA approved type of service.

The Department will establish a start-up rate for the new type of service in accordance with rule 5101:3-28-09 of the Administrative Code. The rate will be the 60<sup>th</sup> percentile of the rural rate (if the site is rural) or ~~the 60%~~ 60th percentile of the urban rate for the new type of service. After one year of operation of the new service, the FQHC must send in completed cost report in accordance with rule 5101:3-28-10 of the Administrative Code.

Additional Information:

Provider handbooks, billing instructions and other provider communications are available on the Department's electronic manual site at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Provider questions pertaining to this MAL should be directed to:

The Bureau of Plan Operations  
Provider Network Management Section  
1-800-686-1516 (toll free)

## **MAL 473 (September 2, 2004 - Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation)**

**Medical Assistance Letter [No 473](#)** is maintained in the Pharmacy Services e-book.

# **MAL 470 (Ohio Medicaid Program Special Requirements for EDI Trading Partners for FQHC/RHC/OHC Claims Submission)**

## **Medical Assistance Letter (MAL) NO. 470**

September 14, 2004

TO: Electronic Trading Partners  
Federally Qualified Health Centers  
Rural Health Centers  
Outpatient Health Facilities  
Directors, County Department of Human Service  
Medical Assistance Coordinators

FROM: THOMAS J. HAYES, DIRECTOR

SUBJECT: Ohio Medicaid Program Special Requirements For EDI Trading Partners For FQHC/RHC/OHC Claims Submission

The purpose of this Medical Assistance Letter (MAL) is to clarify the claims submission requirements for EDI trading partners for FQHC/RHC/OHC claims submission.

This MAL provides specific requirements for the submission of EDI claims for FQHC/RHC/OHC providers.

### **Ohio Medicaid Program Special Requirements for EDI Trading Partners For FQHC/RHC/OHF Claims Submission**

#### **FQHC/RHC/OHF Claims Submission**

1. All EDI claims for FQHCs/RHCs/OHFs must be submitted on the professional (837 P) claim format including dental claims. Never submit dental services provided at a FQHC/RHC/OHF on an 837 dental (837D) claim form.
2. The Medicaid provider number submitted on a FQHC/RHC/OHF EDI 837 P claim must be the Medicaid provider number assigned to the FQHC/RHC/OHF.

In the REF Billing Provider Secondary Identification 2010AA loop and/or 2010AB loop, the following information must be entered:

- a. REF01 Reference Identification Qualifier must be entered as "1D" (Medicaid Provider Number).
- b. REF02 Reference Identification must be the FQHC/RHC/OHF's Medicaid provider number.

Do not submit information in the Rendering Provider loops 2310B or 2420A. For FQHC, RHC, OHF or other clinics, never submit the provider number assigned to the individual professional (e.g. dentist, physician, psychologist, etc.) who treated the patient.

3. Code T1015 must be submitted on all claims with the appropriate two digit modifier to specify the type of encounter provided.

FQHC modifiers are: U1 (medical encounter), U2 (dental encounter), U3 (mental health encounter), U4 (physical therapy encounter), U5 (speech therapy encounter), U6 (podiatry encounter), U7 (vision services encounter), U8 (chiropractic encounter), U9 (transportation encounter).

RHF modifier is: U1

OHF modifiers are: U1 (medical encounter), U2 (dental encounter), U3 (mental health encounter), U4 (physical therapy encounter), U5 (speech therapy encounter), U7 (vision services encounter), UA (lab services encounter), UB (x-ray services encounter), U9 (transportation encounter).

4. All HCPCS procedure codes which describe the services provided during the encounter must be submitted in addition to the modified encounter code (T1015).

5. Since there is not space on the 837P, do not submit tooth numbers or tooth surfaces on dental claims. This is also true for paper claims (HCFA 1500). In the past dental claims that have been denied due to tooth number or tooth surface edits should be resubmitted for payment. This payment system correction has been implemented as of June 25, 2004.
6. Disability Medical Assistance (DMA) and Medicare crossover claims must be submitted under the provider's fee for service provider number (provider type 50) as DMA and Medicare crossover claims services are not covered as cost-based services (provider type 4 OHF, provider type 5 RHC, provider type 12 FQHC).

### **FQHC Supplemental Claims submissions**

1. In the AMT Coordination of Benefits (COB) Payer Paid Amount, 2320 loop the following information must be entered:
  - a. AMT01 Amount Qualifier Code must be entered as "D" (payer amount paid).
  - b. AMT02 Monetary Amount must be equal to the payment by the Medicaid managed care plan (MCP) for the service provided. This amount must always be greater than zero.
2. In the NM1 Other Payer Name 2330B loop, the following information must be entered:
  - c. NM108 Identification Code Qualifier must be entered as PI (payer identification).
  - d. NM109 Identification Code must be the Medicaid provider number for the Medicaid managed care plan (MCP).

Do not submit the Medicaid provider number assigned to the Medicaid managed care plan in the referring provider loops (2310A and/or 2420E) ordering provider.

Provider handbooks, billing Instructions and other provider communications are available on the Department's electronic manual site at:

<http://emanuals.odjfs.state.oh.us/emanuals>

The Department's 837 companion guides are available at:

<http://hipaa.oh.gov/odjfs/companionguides.htm>

Provider questions pertaining to this MAL should be directed to:

The Bureau of Plan Operations

Provider Network Management Section

In State: 1-800-686-6108 (toll free) or (614) 728-3288

Out-of-State: (614) 728-3288

EDI trading partner questions pertaining to this MAL should be directed to:

The Bureau Of Information Services

EDI Support

614-387-1212

**MAL 460 (December 18, 2003 - Consumer co-payments for prescription medication requiring prior authorization)**

**Medical Assistance Letter [No 460](#)**, is maintained in the Pharmacy Services e-book.

## **MAL 456 (September 15, 2003 - Preferred Drug List (PDL) Information)**

**Medical Assistance Letter [No 456](#)** is maintained in the Pharmacy Services e-book.

**MAL 450-A (July 28, 2003 - Prenatal care reimbursement- Important Billing Change)**

**Medical Assistance Letter [No 450-A](#)** is maintained in the Physician Services Handbook.

## **MAL 447 (March 6, 2003 - Preferred Drug List (PDL) Information)**

**Medical Assistance Letter [No 447](#)** is maintained in the Physician Services Handbook.

# MAL 442 (Billing Changes Due to H.I.P.A.A.)

## Medical Assistance Letter (MAL) No. 442

March 4, 2003

TO: Federally Qualified Health Centers  
Directors, County Department of Job and Family Services

FROM: Thomas Hayes, Director

SUBJECT: Billing Changes Due to the Health Insurance Portability and Accountability Act (H.I.P.A.A.)

### **BILLING CHANGES EFFECTIVE OCTOBER 1, 2003**

This is an advance notice of billing changes necessary because of provisions in the Health Insurance Portability and Accountability Act (H.I.P.A.A.). First, H.I.P.A.A requires all payers to use standard code sets. The standard code sets include the AMA CPT coding system and the Health Care Procedural Coding System (HCPCS).

Second, if electronic claims are billed, H.I.P.A.A requires that all payers accept standard electronic transactions. One of these transactions is the claim transaction called the 837 transaction. There are claim transactions for professional providers called the 837 P (professional) transaction and a related but separate transaction for institutional providers called the 837 I (institutional) transaction. Both of these issues (standard code sets and claim transactions) cause Ohio Medicaid to revise its billing procedures for FQHCs as well as for other providers.

This MAL addresses the changes for FQHCs. We want to give FQHCs plenty of time to review your billing system to accommodate these changes.

- Billing changes:

For services provided on or after October 1, 2003, follow the billing instructions applicable for services provided on and after that date. The FQHC may choose to submit a paper claim or an electronic transaction:

- (1) If the FQHC chooses to submit a paper claim, the FQHC must submit a CMS 1500 claim form. The JFS 6780 claim form is being discontinued.
- (2) If the FQHC chooses to submit an electronic transaction, the FQHC must submit an 837 professional transaction.

- Coding Changes:

For services provided on or after October 1, 2003, submit the following data elements unique for FQHC billings:

- (1) Enter the code T1015. The Y codes are not H.I.P.A.A. compliant and can no longer be used.
- (2) Modify the code to specify the type of encounter provided, e.g. T1015U1 or T1015U2 (no spaces, no dashes):
  - (a) For a medical encounter, use the modifier U1;
  - (b) For a dental encounter, use the modifier U2.
  - (c) For a mental health encounter, use the modifier U3;
  - (d) For a physical therapy encounter, use the modifier U4;
  - (e) For a speech therapy encounter, use the modifier U5;
  - (f) For a podiatry encounter, use the modifier U6;
  - (g) For a vision services encounter, use the modifier U7;
  - (h) For a chiropractic encounter, use the modifier U8; and

(i) For a transportation encounter, use the modifier U9.

(3) Enter all the procedure codes that describe the services provided during the encounter.

- Code crosswalk:

<b>Code Crosswalk</b>		
<b>Current local level code:</b>		<b>New code and modifier after HIPAA:</b>
Y0001	Medical	T1015U1
Y0002	Mental health	T1015U3
Y0003	Physical therapy	T1015U4
Y0004	Speech therapy	T1015U5
Y0005	Dental	T1015U2
Y0006	Podiatry	T1015U6
Y0007	Vision	T1015U7
Y0008	Chiropractic	T1015U8
Y0009	Transportation	T1015U9
Y0015	Dental follow-up	T1015U2

- Supplemental payment claims:

If the claim is for a supplemental payment, follow the coding and billing instructions in this MAL. In addition, submit the unique data elements required for a supplemental payment:

The data elements submitted for a supplemental payment claim are dependent on whether the claim is a paper claim or an electronic transaction, e.g. 837 professional:

- (1) If the FQHC chooses to submit a paper claim, submit the same data elements currently being submitted and outlined in MAL 394 with the following exception:  
Instead of billing the local level codes (Y0001 through Y0015) to signify the type of encounter, follow the instructions in this MAL and bill the new T code and the appropriate modifier to specify the type of encounter.
- (2) If the FQHC chooses to submit an electronic transaction, use the 837 professional transaction. Report the data elements unique for supplemental claims:
  - (a) Enter the name of the MCP provider under the "other payer name" field;
  - (b) Enter the "identification code" of the other payer (the MCP) which initially paid for the services. The identification code is assigned by Ohio medicaid;
  - (c) Enter the sum of the dollar amount the FQHC was paid by the MCP for the services minus any incentive payments received by the MCP plus any amount received from any other third party insurance. Enter this amount as the "monetary amount" in the "other payer" area.

**Questions pertaining to this MAL should be addressed to:**

**The Bureau of Plan Operations**

**The Provider Network Management Section**

**P.O. Box 1461**

**Columbus, OH 43216-1461**

**In state toll free telephone number 1-800-686-6108**

**Out-of-state telephone number 614-728-3288**

# **MAL 402 (Federally Qualified Health Centers: Revised Rules)**

## **Medical Assistance Letter (MAL) No. 402**

December 13, 2001

TO: All Federally Qualified Health Centers  
Directors, County Departments of Job and Family Services  
Directors, District Offices

FROM: Tom Hayes, Director

SUBJECT: Federally Qualified Health Centers: Revised Rules

### **FQHC SERVICES**

#### **EFFECTIVE MARCH 1, 2002**

The purpose of this Medical Assistance Letter (MAL) is to inform Federally Qualified Health Centers (FQHCs) of proposed revisions made to existing FQHC rules made as a result of review of existing FQHC rules in conjunction with Ohio Revised Code Section 119, which requires each agency to review its rules once every five years. The revised FQHC rules (5101: 3-28-01 through 5101: 3-28-04) are attached. These rules are still in a proposed status will be effective March 1, 2002.

#### **Policy Clarifications/ Revisions:**

- **Eligibility**
  - A provider who meets the eligibility conditions as an FQHC is not eligible to enroll as a rural health clinic or as an outpatient health facility.
  - If an eligible FQHC has a current provider number as either an outpatient health facility or a rural health clinic, the eligible FQHC must bill for services under their FQHC provider number. Providers may be enrolled as only one type of alternative payment clinic. As "alternative payment clinic" shall be defined as an FQHC, rural health clinic, or outpatient health facility.
- **Covered Services**
  - Language in the FQHC covered services rule has been broadened for advanced practice nurses. Since the term "advanced practice nurse" includes a nurse practitioner, nurse mid-wife, or clinical nurse specialist, the Department's rules have been revised to specify that an advanced practice nurse is eligible to enroll as a Medicaid provider and certified by a national certifying organization for their area of specialty is eligible to furnish services as an FQHC.
  - The category of service "mental health services" has been expanded to include the service on a licensed professional counselor as defined in the mental health services section of the physician handbook (recently updated) and the services of an advanced practice nurse certified by a national certifying organization in the specialty of psychiatry.
- **Billable Services**
  - The following is not a change in policy but a clarification of an existing procedure. Certain services are not considered covered FQHC services. The FQHC's costs for these services are not included in the rates established for "core" or "non-core" services. These services should be billed by an FQHC under a separate Medicaid provider number as a fee-for-service ambulatory care clinic:
    - Inpatient hospital surgery;
    - Inpatient hospital visits or consultations;
    - Medicare crossover claims;
    - Disability assistance program claims;

- Take home drugs should be billed through the pharmacy program as described in Chapter 5101: 3:9 of the Administrative Code; and
- Durable medical equipment (DME) for take-home use should be billed through the DME program as described in Chapter 5101: 3-10 of the Administrative Code.

**Questions pertaining to this MAL should be addressed to:**

**The Ohio Department of Jobs and Family Services**

**Bureau of Plan Operations**

**The Provider Network Management Section**

**P.O. Box 1461**

**Columbus, OH 43216-1461**

**In-state toll free telephone number 1-800-686-6108**

**Out-of-state telephone number 1-614-728-3288**

**Attachment**

5101:3-28-01 Eligibility.

5101:3-28-02 Covered services.

5101:3-28-03 Coverage and limitation policies for federally qualified health centers.

5101:3-28-04 Billable services.

# **MAL 400 (Federally Qualified Health Centers: New Prospective Payment System)**

## **Medical Assistance Letter (MAL) No. 400**

### **Attachment**

5101:3-28-08FQHC: PROSPECTIVE PAYMENT SYSTEM

5101:3-28-09FQHC: PROSPECTIVE RATE REVIEW FOR CHANGE IN SCOPE OF SERVICE.

5101:3-28-10FQHC: PROSPECTIVE PAYMENT SYSTEM COST REPORT.

November 7, 2001

TO: All Federally Qualified Health Centers  
Directors, County Departments of Job and Family Services  
Directors, District Offices

FROM: Tom Hayes, Director

SUBJECT: Federally Qualified Health Centers: New Prospective Payment System

### **FQHC SERVICES**

#### **EFFECTIVE RETROACTIVE TO JANUARY 1, 2001**

The purpose of this Medical Assistance Letter (MAL) is to inform Federally Qualified Health Centers (FQHCs) of the method which will be used by the Department to reimburse FQHCs under a new prospective payment system (PPS) required under the Benefits Improvement and Protection Act (BIPA) of 2000 which is retroactive to January 1, 2001. The reimbursement provisions described in this MAL have been approved by the Center for Medicare and Medicaid (CMS).

Section I. of this MAL addresses the basic Prospective Payment System (PPS) concepts. Section II. and section III. of this MAL addresses provisions relating to a "change in scope of service". Section IV. describes the new cost report and the circumstances under which FQHCs must submit this cost report.

The rules addressing the new PPS system (5101: 3-28-08 through 3-28-10) are attached and are scheduled to be effective on October 25, 2001 but are retroactive to January 1, 2001. Also enclosed is the JFS 3421 cost report and its instructions.

#### **I. New Prospective Payment System:**

##### **Definitions:**

- "Base PPS rate(s)" shall be the term used for the initial PPS rate(s) for an FQHC.
- "Change in scope of service" means the addition or deletion of a new category of service. An FQHC also may request review of a situation they believe should be considered as a change in scope of service. This procedure is described in Section II. of this MAL.
- "Category of service" means the following different types of service:
  - Medical;
  - Dental;
  - Physical therapy;
  - Podiatry;
  - Optometry;
  - Chiropractic;
  - Speech therapy and audiology;
  - Mental health specifically services of a clinical psychologist or clinical social worker; and

Transportation.

- "Increase or decrease in the scope of services" means the addition or deletion of a new category of service.

### **Phase One of the new Medicaid PPS system:**

For dates of service January 1, 2001 through September 30, 2001 (the first phase of the new prospective payment system) the Department will pay current FQHCs one hundred percent of the average of their costs for providing Medicaid-covered services during calendar year 1999 and calendar year 2000 (ie. FQHC Medicaid program fiscal year) which are reasonable and related to the costs of furnishing such services. The determination of reasonable and related costs are based on tests of reasonableness as defined in paragraphs (D), (E), (F), and (H) (2) (a) and (b) of rule 5101:3-28-05 of the Administrative Code except that:

- The ceiling on administrative and general costs described in paragraph (E) of rule 5101: 3-28-05 of the Administrative Code shall be increased to thirty-five per cent;
- The wage index described in paragraph (H) (2) of rule 5101: 3-28-05 of the Administrative Code used to establish the baseline rates will be the most recent wage index published in the Federal Register for the year 2000.
- Instead of the "statewide urban mean" and the "statewide rural mean" described in paragraph (H) (2) (a) and (H) (2) (b) of rule 5101: 3-28-05 of the Administrative Code. the Department will use the sixtieth percentile for urban FQHCs and the sixtieth percentile for rural FQHCs.
- The test of reasonableness for transportation services shall be increased to twenty dollars per one-way unit of service to and/or from a Medicaid-covered FQHC service.

The Department will use the cost-based interim rates established from the rate methodology described earlier in this MAL and in rule 5101:3-28-05 of the Administrative Code for calendar year 1999 and calendar year 2000 and will take the average of these rates for each FQHC to arrive at the base PPS rate(s) by category of service for each FQHC for January 1, 2001 through September 30, 2001.

The resulting average rate will be adjusted, if necessary, to take into account any increase or decrease in the scope of services as defined in this MAL furnished during calendar year 2001. The rate-setting method described in Section II. of this MAL will be used to establish the rate for the service which has change in scope.

### **October 1st Changes:**

Beginning October 1, 2001, and on October 1<sup>st</sup> of each year thereafter, the following procedures will occur:

- All prospective payment system rates in effect on September 30th will be inflated by the percentage increase in the Medicare Economic Index (MEI) for primary care services; and
- The Department will calculate the sixtieth percentile for urban and for rural FQHCs. The most recently calculated sixtieth percentile will be used for any rate assignments occurring between October 1st and September 30th due to changes in scope of service as described in paragraph (A) of rule 5101: 3-28-09 of the Administrative Code (section II. of this MAL) or for the start-up rate for newly-qualified FQHCs.
- The transportation payment value in effect on September 30th will be inflated by the percentage increase in the latest available MEI for primary care services. The most recently calculated transportation value will be used for any rate assignments occurring from October 1<sup>st</sup> to September 30th.

### **Newly qualified FQHCs:**

After state fiscal year 2002, newly-qualified FQHCs will have their base PPS rates set based on the rates established for other FQHCs in the nearest adjacent area which are similar in size, caseload, and scope of services. If there is no FQHC in the nearest adjacent area which is similar in size, caseload, and scope of services, the state-wide urban or state-wide rural sixtieth percentile rate in effect on October 1<sup>st</sup> of that year

for all FQHCs offering that particular category of service will be assigned to the newly-qualified FQHC for the first year start-up rate.

After the start-up rate is set, the following procedures will occur:

- The newly-qualified FQHC will file a cost report in accordance with section III. of this MAL.
- The PPS base rate(s) for the newly qualified FQHC will be set based on the newly-qualified FQHC's costs reported on their cost report and based on the principles described in section II. of this MAL.
- The start-up rate(s) will be adjusted. The new PPS base rate will be the cost-based rate established using the principles described in section II. of this MAL adjusted by any MEI increases which may have occurred since the filing of the FQHC's cost report.
- The rate will be effective within sixty days of receipt of a complete and accurate cost report.

The wage index used to establish the rate(s) for newly-qualified FQHCs shall be the most recent wage index applicable to the newly-qualified FQHC's location published in the Federal Register for the year in which the new FQHC is eligible to become an Ohio Medicaid provider.

In future years, rates for newly-qualified FQHCs will be set using the MEI method used for other FQHCs.

### **Retroactive Adjustments:**

FQHCs will receive payments for the period January 1 through September 30, 2001 based on the new prospective payment system rates retroactively. Until the base PPS system rates are established, providers will continue to be paid using the interim rates set for state fiscal year 2001.

### **Other Changes:**

In addition to the exceptions listed in the section "Phase One of the PPS System" the following changes will be in effect:

- Annual cost report filing shall no longer be required, except for the situations described in section III, the cost-reporting section of this MAL;
- The provisions of paragraphs (H) (4) and (H) (5) of rule 5101: 3-28-05 of the Administrative Code which addresses interim settlements shall not apply;
- Audits and final settlements will no longer be required.

## **II. Prospective Rate Review for a Change in Scope of Service:**

There are two methods for making adjustments for changes in scope of service. This section describes the methodology which will be used to establish the rate for a service which has changed in scope of service occurring when an FQHC adds or deletes a new category of service.

- As an interim step, FQHCs which establish a new category of service will be given a start-up rate for the new category of service. The start-up rate for urban FQHCs will be the sixtieth percentile of the values for all urban FQHCs offering that category of service that were in effect on October 1<sup>st</sup> of the year that the FQHC added a new category of service.. For rural FQHCs, the start-up rate for the new category of service which will be the sixtieth percentile of the values for all rural FQHCs offering that category of service that were in effect on October 1<sup>st</sup> of the year that the FQHC added a new category of service. This interim rate will be in effect until a rate for that FQHC for that category of service is established by the department based on the methodology described in this MAL.
- Any FQHCs adding a new category of service must file two cost reports in accordance with the instructions specific for the JFS 03421 and within the time frames stated in Part III of this MAL:
  - The first cost report shall cover the twelve month period beginning the first day of the first full month after the new category of service began operation; and
  - The second cost report shall cover the twelve month period beginning the first day of the first full month new the new category of service began operation..

- Upon receipt of a complete and accurate cost report, the department will review the FQHC's costs for the service which has changed in scope of service and will adjust the interim rate based on the reasonable cost parameters described in this MAL.
- Reasonable Cost Parameters

### **General Provisions for Allowable and Reasonable Costs.**

"Costs which are reasonable and related to patient care" are those contained in the following reference material in the following priority: "42 CFR part 413 Principles of reasonable cost reimbursement," "health insurance manual 15-1 provider reimbursement manual," and "generally accepted accounting principles"; except that:

- Costs related to patient care and services that are not covered under the FQHC program as described in Chapter 5101:3-28 of the Administrative Code are not allowable.
- The straight line method of computing depreciation is required for cost filing purposes, and it must be used for all depreciable assets.
- For purposes of determining allowable and reasonable cost in the purchase of goods and services from a related party, the following definition of related shall be used: "Related" is one who enjoys, or has enjoyed within the previous five years, any degree of another business relationship with the owner or operator of the facility, directly or indirectly, or one who is related by marriage or birth to the owner or operator of the facility.
- Upper limits for costs associated with related party transactions are defined as the following:  
FQHCs are required to identify all related organizations; i.e., related to the FQHC by common ownership or control. The cost claimed on the cost report for services, facilities, and supplies furnished by the related organization shall not exceed the lower of:
  - The cost to the related organization; or
  - The price of comparable services, facilities, or supplies generally available.

Tests of reasonableness, ceilings and upper limits as identified in this MAL shall be applied in determining allowable and reasonable cost.

### **Ceilings on Administrative and General Costs**

- A thirty-five per cent ceiling for total allowable administrative and general and overhead costs shall be applied to all services. Total allowable administrative and general and overhead costs are defined as costs reported on the JFS 3421, schedule C-1, Part II and schedule C-2 parts III and IV, plus any allowable costs to these costs areas from schedule C-1, Part I of the JFS 3421.
- An annual exemption of thirty thousand dollars per year per provider from the ceiling on administrative and general costs is allowable for the recruitment costs of core providers.

### **Tests of Reasonableness for Professional Services and Transportation.**

- Allowable costs reported to the department in accordance with the instructions for the JFS 3421 will be adjusted based on minimum required efficiency standards calculated as encounters per hour. The rate established for the following service components will not exceed the lower of the rates as determined by dividing allowable costs by allowable encounters or allowable costs divided by the product of direct hours worked by the professional and the encounters per hour as shown below:
  - Physician services - 2.4 encounters per hour per physician;
  - Physician assistant or advanced practice nurses services - 1.2 encounters per hours per practitioner;
  - Clinical social worker and psychology services -.7 encounters per hour;
  - Physical therapy services - 2.0 encounters per hour;

- Speech pathology and audiology services - 1.8 encounters per hour;
  - Dental services - 1.8 encounters per hour;
  - Podiatry services -2.4 encounters per hour;
  - Optometric/optician services - 2.3 encounters per hour; and
  - Chiropractor services - 2.4 encounters per hour;
  - Transportation reimbursement shall not exceed twenty dollars per one way unit of service to and/or from a medicaid covered FQHC service for dates of service prior to October 1, 2001. For dates of service on or after October 1, 2001, the transportation value shall be inflated on October 1st of that year by the increase in the latest available MEI for primary care services.
- Reimbursement rates shall not exceed the higher of the appropriate Medicare ceiling or the wage adjusted ceilings on reimbursement rates as follows:
    - Using as filed the JFS 3421 for each eligible FQHC site, an allowable cost per encounter for any new category of service shall be calculated. Tests of reasonableness, ceilings, and upper limits identified in this MAL shall be applied to the as filed cost of each eligible FQHC site prior to calculation of the percentile cost per encounter.
    - The urban wage adjustment factor is the adjustment factor for the FQHC's location published in the Federal Register for the year in which the FQHC rate is being established divided by the current year's Ohio rural wage index.
    - The statewide urban percentile cost per encounter is the sixtieth percentile of the values of all urban facilities' allowable cost per encounter that were in effect on October 1st of that year for entities receiving a grant under section 329, 330, or 340 of the Public Health Service Act. The statewide rural percentile cost per encounter is the sixtieth percentile of the values of all rural facilities' allowable cost per encounter that were in effect on October 1st of that year for entities receiving a grant under section 329, 330, or 340 of the Public Health Service Act.
    - The final ceilings on core and noncore service reimbursement for each rural facility is the statewide rural sixtieth percentile as set forth in this MAL. The final ceilings on core and noncore service reimbursement for each urban facility is calculated by multiplying the statewide urban sixtieth percentile as set forth in this MAL by the adjustment factor for the FQHC's metropolitan area obtained from the most recent Ohio wage index published in the federal register for the year in which the FQHC's rate is being established.

The payment rate shall not exceed the higher of the Medicare ceiling or the wage adjusted ceilings for reimbursement rates as set forth in this MAL.

The final rate for the service which has changed in scope of service will be effective within sixty days of receipt of a complete and accurate cost report.

### **III. Request for Review of a Change in Scope of Service- Method II**

An FQHC also may request a review for a determination of a change in scope of service if the provisions described in section II. of this MAL do not apply, e.g. the FQHC did not add a new category of service.

A change in scope of service may include but is not limited to the following:

- The addition of a service which has been mandated by a governmental entity such as the health resource services administration (HRSA) in federal statute, rules, or policies enacted or amended after January 1, 2002;
- The addition of an obstetrical-gynecological physician to an FQHC site which did not previously offer obstetrical services;
- The addition of a dentist to a site which only offered dental hygienist's services previously. The site did not previously employ a licensed dentist and did not offer the full scope of dental services; or

- A significant increase in the intensity of services provided.

The following situations would not be considered a change in scope of services:

- Wage increases;
- Negotiated union contracts;
- Renovations;
- The addition of a disease management program;
- An increase in the number of staff working in the clinic such as the addition of:
  - A lower level staff member such a family nurse practitioner when a site employs a family physician.
  - A hygienist when a dentist is employed at the site;
  - A physician therapy assistant when the site employs a physical therapist; and
  - Social service staff.
- An increase in office space which is not directly associated with an approved change in scope of service, e.g the increase of an obstetrical-gynecological physician;
- An increase in equipment or supplies which is not directly associated with an approved change in scope of service, e.g. the increase an obstetrical-gynecological physician;
- An increase in patient volume; and
- An increase in office hours.

An FQHC's request for a rate increase due to a change in scope of service will be granted at the sole discretion of the Department. The calculated cost-based rate for the service which changed in scope must increase by at least twice the MEI for that year before the department will grant the request for a change in scope of service.

A rate review for a change in scope of service shall not increase a rate in excess of any rate limitations, ceilings, or tests of reasonableness set forth in Administrative Code.

Request for review of a change in scope of service must be filed no later than ninety days after the close of one year of operation of the service which has changed in scope.

A rate adjustment due to a change in scope shall be granted only once for a particular circumstance for a particular FQHC.

A request for rate review due to a change in scope of service must be filed in accordance with the following procedures:

- The request for review of a change in scope of service must be in writing;
- The request for a rate review must indicate that it is due to a change in scope of service;
- The request for a rate review must provide a detailed explanation and evidence to prove why a rate adjustment is warranted. The FQHC must demonstrate that by providing either:
  - A community needs assessment shows that population demographic changes warrant the change in scope of service; or
  - A business plan or other similar documentation indicates that the new service is warranted; and
  - Efforts were made to address the problem outside of the rate review process.
- If the request is due to a change in the intensity of services provided, the FQHC must provide evidence that the intensity of services has changed and that increased costs are directly related to the change in intensity of service. This evidence might include a report showing that patients' diagnoses have

significantly changed the acuity of care or a report proving that the relative values of the services provided has changed significantly.

- The FQHC must file two complete cost reports which include all schedules and attachments specified for the JFS 03421 cost report and documentation supporting the cost increase. The FQHC must specify in their written request exactly what cost centers in the cost report have been impacted by the increased costs for the service which has changed in scope and why they were impacted.
  - A cost report must be filed for the twelve month period beginning on the first day of the first full month after the service which has changed in scope began operation;
  - A cost report must be filed for the twelve month period beginning on the first day of the first full month for the twelve-month period before the service which has changed in scope began operation;
  - The cost reports and all required documents listed in this MAL must be filed within ninety days after the close of the first twelve months of operation of the service which has changed in scope; and
  - Failure to file the cost reports within the time period specified will mean that the department will not evaluate the request for consideration of a change in scope.
- The Department shall respond in writing within sixty days of receiving each written request for a change in scope of service. If the Department requests additional information to determine if the rate request is warranted, the Department shall respond in writing within sixty days of receiving the additional information.
- If a request for a rate adjustment due to a change in scope of service is granted, the following provisions will apply:
  - The department will review the FQHC's costs for the service which has changed in scope and will set a rate based on the reasonable cost parameters described in this MAL.
  - The rate increase shall be the difference between the rate calculated for the service which has changed in scope submitted on the cost report minus the rate previously calculated for the prior year for that category of service. The rate increase amount shall be added to the current year's prospective payment rate for that specific category of service for the FQHC.
  - The rate shall be inflated by the MEI on October 1st of each year.
  - The rate adjustment shall be effective on the first day of the first full month after the department has granted the request. Retroactive adjustments will not be made.

The Department's decision at the conclusion of the rate review process shall not be subject to any administrative proceedings under Chapter 119 of the Administrative Code.

An FQHC must notify the Department in writing of any permanent decrease in the scope of any service. For example, if the FQHC stops offering a certain category of service, ie. no longer offers dental services, the Reimbursement Section of Health Plan Policy, in the Office of Medicaid must be notified.

#### **IV. New Cost Report**

If the following situations apply to an FQHC, the JFS 03421 cost report must be filed with the department:

- An entity is newly-qualified as an FQHC on or after July 1, 2001.
- An existing FQHC has added a service which has changed in scope because the FQHC began providing a new category of service such as dental, vision, mental health, etc.; or
- An FQHC has requested that the department review a request for a change in scope of service as described earlier in this MAL.

Filing requirements

- If a cost report is required because the FQHC is a newly-qualified FQHC, the cost report must be filed within ninety days after the close of one full year of operation of the new category of service or the operation of the new FQHC. The cost report shall be filed in accordance with the instructions specified for the JFS 03421 and must cover the period beginning the first day of the first full month after the new category of service was added by the FQHC or the first day of the first full month after the new FQHC became qualified as an FQHC.
- If cost reports are required because the FQHC has requested a review of a change in scope of service or because an FQHC has added a new category of service as defined earlier in this MAL, two cost reports must be filed in accordance with the instructions specified for the JFS 03421. The provisions for filing these two cost reports are described in this MAL.

Failure to file complete and accurate cost reports within the time frames established in this MAL will result in the department making no adjustments to the rate(s) for a service which the FQHC claims has changed in scope of service. No extensions will be granted for cost report filings.

The cost report to be submitted by the FQHC shall be supplied by the Department. The FQHC must request the computer diskette containing the cost report from the Department by contacting the manager of financial operations within the Bureau of Health Plan Policy in the Office of Medicaid. A hard copy of this cost report and report instructions are attached to this MAL.

The FQHC must complete and return the computer diskette containing the cost report to the department within the time frames stated in this MAL. A paper copy of the completed cost report shall accompany the completed diskette version of the FQHC's cost report.

If you have any questions relating to this reimbursement methodology or rates, please call our reimbursement manager, Roy Sutton at 614-466-6420.

**Questions pertaining to this MAL should be addressed to:**

**The Ohio Department of Jobs and Family Services**

**Bureau of Plan Operations**

**The Provider Network Management Section**

**P.O. Box 1461**

**Columbus, Oh 43216-1461**

**In-state toll free telephone number 1-800-686-6108**

**Out-of-state telephone number 1-614-728-3288**

# MAL 394 (Supplemental Payments to Federally Qualified Health Centers)

Medical Assistance Letter (MAL) No. 394

Attachment:

[JFS 03454W, FQHC - MCP Medicaid Encounter Worksheet For Services Provided, January 1, 2001 - June 30, 2001](#)

July 13, 2001

TO: All Federally Qualified Health Centers  
Directors, County Departments of Job and Family Services  
Directors, District Offices

FROM: Greg Moody, Director

SUBJECT: Supplemental Payments to Federally Qualified Health Centers

## FQHC SERVICES

### RETROACTIVE TO JANUARY 1, 2001

The purpose of this Medical Assistance Letter (MAL) is to inform Federally Qualified Health Centers (FQHCs) of the Department's method to reimburse FQHCs for managed care supplemental payments (also known as wraparound payments). This reimbursement is required under the federal Benefits Improvement and Protection Act of 2000 (BIPA). This MAL is being released now so that FQHCs can begin to prepare themselves for implementing the proposed supplemental payment process.

Please note that the provisions in this MAL are contingent upon approval of the Department's State Plan Amendment submitted to the Health Care Financing Administration (HCFA). **This policy will not be in effect until the Department receives final approval on Ohio's State Plan Amendment from HCFA. When the Plan is approved, the Department will notify all FQHCs via a remittance advice newsletter of the effective date of this policy.** In the event that the State Plan Amendment is not approved, this policy may be revised and new instructions issued.

**Until you have received a notice from the Department of the effective date, please do not submit either the JFS form 3454W or any claims.**

Any supplemental payments made during the period prior to the date the rate methodology for the new prospective payment system is finalized (and a rule is effective) will be paid at the rate in effect on the processing date. Upon implementation of prospective payment rates, an adjustment will be made to any payments made prior to implementation of prospective payment system rates.

### I. For Services Provided on or After January 1, 2001 to June 30, 2001:

For services furnished on or after January 1, 2001, FQHCs are eligible to receive a quarterly supplemental payment from the Department. FQHCs are eligible to receive these payments if the amount the FQHC was paid by a managed care plan (MCP) for services provided to a Medicaid recipient enrolled in a managed care plan is less than the amount the FQHC would have received under the cost-based reimbursement method described in rule 5101:3-28-05 of the Administrative Code.

In order to receive quarterly payments, each FQHC may complete the JFS 3454W MCP worksheet. The worksheet must be submitted to the department no later than one hundred and eighty days after the close of each quarter. The deadline for filing quarterly reports therefore is as follows:

Service Dates:	Filing Deadline:
January 1 through March 30, 2001	September 30, 2001

April 1 through June 30, 2001	December 31, 2001
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The department will accept only one report for each of the quarters listed above. Thus, before filing the report the FQHC must ensure:

1. All payments from all MCPs are received prior to filing the JFS 3454W form for the supplemental payment. **A second JFS 3454 form with additional claims submitted for a quarter for which a JFS 3454 has already been submitted will not be accepted.**
2. Use the JFS 3454W form with the revised date of 6/2001.
3. The following data must be reported for dates of service on and after January 1, 2001 to June 30, 2001:
  - (a) The **total** quarterly revenues for **dates of service** on and after January 1- June 30, 2001 (including any capitation payments) received from each Medicaid MCP for furnishing care to Medicaid recipients enrolled with an MCP.

**Note: The revenues submitted must match the encounters reflected on the second portion of the JFS 3454.**

- (b) An FQHC must report the total quarterly encounters for **dates of service** on and after January 1- June 30, 2001 for each category of service established for that FQHC. For example, if an FQHC provided medical, dental, and podiatry services, the number of encounters for each type of service must be reported.

### **Instructions for Completing Form 3454 - The FQHC-MCP Medicaid Encounter Worksheet:**

#### **Section I:**

- Enter the name of the MCP on the line that begins with MCP Name.
- Report, for each quarter, all revenues your facility has received from all MCP's for **MEDICAID ELIGIBLE** patients for the encounters you are reported in Section II.

#### **Section II:**

- For each FQHC Service Type enter the assigned ODJFS 'Interim Rate' that was in effect for the fiscal services periods specified on the form in the boxes under MCP 2 and to the right of "ODJFS Rate". To verify the correct ODJFS interim rate amount, please refer to your FQHC rate letters.
- For each FQHC Service Type enter the number of **MEDICAID BILLABLE ENCOUNTERS** (by date of service) for each MCP for each quarter. For the purpose of this rule an encounter is the same as defined in 5101:3-28-04 of the Revised Code.

*Note: The Department will receive reports from the MCPs listing payment and utilization data for each FQHC and will compare the data submitted by both parties. Should there be a discrepancy between the data submitted by the FQHC and the MCP data, the Department will use the lower encounter and higher revenue figures. FQHCs may submit documentation to the Department, e.g. remittance advice detail from the MCP, to confirm the data they have reported on the JFS 3454W form. Any clarifying information must be submitted within thirty (30) days of the date the FQHC received the Department's notice of the discrepancy.*

Upon receipt of a complete and accurate JFS 3454W and comparison of data to MCP information, the Department will pay the FQHC no less frequently than every four months.

Questions pertaining to the completion of the JFS 3454W form, should be directed to Roy Sutton or Doug Henkel in the reimbursement section of Health Plan Policy at 614-466-6420.

#### **II. For Services Provided on or After July 1, 2001:**

Effective for services furnished on and after July 1, 2001, to receive the supplemental payment, an FQHC first must bill the MCP and receive the MCP payment for services provided. Then the FQHC must submit a claim to the Department for **each** encounter following the Ohio Medicaid provider billing instructions.

Either through electronic submission or on a claim form, the FQHC must document the following information relevant to the supplemental payment. These items are in addition to completion of the other portions of the claim form.

- (1) The local level code (Y0001 through Y0015) which signifies the type of encounter provided by the FQHC;
- (2) A detailed CPT code listing of all services provided during the encounter;
- NEW* (3) In the block entitled "Reserved for local use ("AKA:Other Source" enter the "Other source code" of "8", "Supplemental (Wraparound) Payment".
- NEW* (4) In the block entitled "ID Number of Referring Physician", enter the Medicaid identification number of the MCP which paid the initial claim to the FQHC. See attached list of Medicaid MCPs with their identification numbers or check the ODJFS web site for the latest listing of MCPs. The web site address for this document is <http://www.state.oh.us/odjfs/ohp/bmhc/mcplistprov.PDF>.
- NEW* (5) In the block entitled "Amount Paid (AKA Other Source)", enter the amount collected from all sources other than Medicare. Enter the addition of the dollar amount the FQHC was paid by any MCP for the service(s) provided to the Medicaid recipient and any amount received by the FQHC from any other third party insurance. If the amount collected from all sources other than Medicare exceed the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment.
- (6) In the block entitled, "Balance due (AKA Net charge)", enter the difference between the total charge and the amount received from other sources.

*Note: On the Medicaid recipient's identification card from his/her managed care plan, the recipient's Medicaid number may be noted as the "MMIS No.". This is the identification number you must use to submit the fee-for-service claim for supplemental payment.*

Upon receipt of the claim, the Department will pay any difference between the amount paid by the MCP to the FQHC and the amount due the FQHC based on their approved cost-based rate and payments from any other sources. This payment will be on a claim-by-claim basis and will be paid at the normal frequency of regular claim payments. As stated in BIPA legislation, the payments will be no less frequently than every 4 months.

The Department's supplemental payment obligation will be determined using the baseline payment that the FQHC would have received under cost-based reimbursement without regard to the effects of any financial incentives (positive or negative) that are linked to utilization outcomes or other reductions in patient costs.

If a claim is not submitted by an FQHC to the Department within the standard time frames specified for claims submission (specified in paragraph G of rule 5101:3-1-193 of the Administrative Code), no supplemental payment(s) will be made by the Department to the FQHC.

**Questions pertaining to this MAL should be addressed to:**

**The Ohio Department of Jobs and Family Services**

**Bureau of Plan Operations**

**The Provider Network Management Section**

**P.O. Box 1461**

**Columbus, OH 43216-1461**

**In-state toll free telephone number 1-800-686-6108**

**Out-of-state telephone number 1-614-728-3288**

# **OAC Rules Related to Federally Qualified Health Centers**

MAL 508

**Effective Date: July 1, 2006**

**Most Current Prior Effective Date: March 1, 2002**

- (A) ~~Federally~~ A federally qualified health center (FQHC) ~~eligibility is determined in two ways is:~~
- (1) An entity that has entered into an agreement with the centers for medicare and medicaid services (CMS) to meet medicare program requirements and is receiving a grant under section 329, 330, or 340 of the Public Health Service Act is an FQHC or is receiving funding from such a grant under a contract with the recipient ~~or of such a grant and meets the requirements to receive a grant under section 329, 330, or 340 of the Public Health Service Act;~~ or
  - (2) ~~A facility is~~ An FQHC look-alike, based on the recommendation of the public health service, determined by the U.S. secretary of health and human services to be an FQHC ~~CMS to meet all the eligibility requirements of an entity to receive a grant under section 330 of the Public Health Service Act, based on the recommendation of the Public Health Service,~~ but does not receive grant funding.
- (B) An FQHC, as determined in accordance with paragraph (A)(1) of this rule, must ~~submit document~~ submit appropriate documentation that each service sites are providing site provides services in accordance with the provisions of ~~329, section 330, or 340~~ section 330 of the Public Health Services Act. ~~This may be done in several ways.~~ Appropriate documentation is any documentation from the health resources and services administration (HRSA) that identifies the specific service site(s) included in the 330 public health services project.
- ~~(1) The various service sites are identified in the grant proposal/amendment and award.~~
  - ~~(2) Public health services identifies to the FQHC that a service site not included in the grant is operated in accordance with the appropriate provisions of the Public Health Services Act.~~
- (C) ~~Service sites qualifying for FQHC reimbursement under~~ An FQHC, as determined in accordance with paragraph (A)(2) of this rule, must submit to the department a copy of the U.S. secretary of health and human services confirmation letter that the service site(s) meet(s) the requirements for receiving a grant under section 330 of the Public Health Service Act and will be considered an FQHC look-alike with respect to medicaid coverage and payment.
- (D) An FQHC, as ~~determined~~ defined in accordance with paragraph (A)(1) of this rule, will be reimbursed as an FQHC in accordance with Chapter 5101:3-28 of the Administrative Code ~~effective January 1, 1991.~~ An FQHC, as ~~determined~~ defined in accordance with paragraph (A)(2) of this rule, will be reimbursed as an FQHC for services provided on and after the date the U.S. secretary of health and human services approval is received by the department.
- (E) ~~A provider who meets the eligibility conditions specified in paragraph (A) of this rule is not eligible to enroll as a rural health clinic or as an outpatient health facility. If an eligible FQHC has a current provider number as either an outpatient health facility or a rural health clinic, the eligible FQHC must bill for services under their FQHC provider number in accordance with policies set forth in Chapter 5101:3-28 of the Administrative Code.~~ Providers may be enrolled as only one type of alternative payment clinic. An "alternative payment clinic" shall be defined as an FQHC, rural health clinic (RHC), or outpatient health facility (OHF).

Effective: 07/01/2006

R.C. 119.032 review dates: 03/09/2006 and 07/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2006

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/10/91, 3/1/02

MAL 508

**Effective Date: July 1, 2006**

**Most Current Prior Effective Date: March 1, 2002**

- (A) "Covered core services" for ~~Federally Qualified Health Centers (FQHCs)~~ FQHCs are ~~those~~:
- (1) Medical Services services furnished by a physician, physician assistant, or advanced practice nurse (as described in ~~rule 5101:3-8-21~~ rules 5101:3-8-20 to 5101:3-8-23 of the Administrative Code, except for an advanced practice nurse providing services relating to mental health services as defined in paragraph (B)(8) of this rule). The services must be within the scope of practice of his or her profession under state law. ~~If the services are performed at the service site or the services are furnished away from the service site, there~~ There must be an agreement with between the FQHC and the health professional providing stating that he or she will be paid by the FQHC for such services.
  - (2) Services and supplies ~~that are~~ furnished as ~~an~~ incident to professional services furnished by a physician, physician assistant, or advanced practice nurse.
  - (3) ~~Part-time or intermittent visiting~~ Visiting nurse ~~care and related medical supplies (other than drugs and biologicals)~~ services if:
    - (a) The service site is located in an area in which the United States secretary of health and human services has determined that there is a shortage of home health agencies;
    - (b) The services are furnished by a registered nurse, a licensed practical nurse employed by, or otherwise compensated for the services by, the FQHC;
    - (c) The services are furnished to a homebound individual; and
    - (d) The services are furnished under a written plan of treatment that is established and reviewed at least every ~~sixty-two~~ sixty days by a supervising physician of the FQHC or that is established by a physician, physician assistant, or advanced practice nurse and reviewed ~~and approved~~ at least every sixty days by a supervising physician of the FQHC and signed by the physician, physician assistant, or advanced practice nurse or supervising physician.
- (B) "Covered noncore services" for FQHCs are those services, other than core services, ~~which~~ that include the following:
- (1) Physical therapy services;
  - (2) Speech pathology and audiology services;
  - (3) Dental services;
  - (4) Podiatry services;
  - (5) Optometric and/or optician services;
  - (6) Chiropractic services;
  - (7) Transportation services; ~~and,~~
  - (8) Mental health services ~~provided by a clinical psychologist, clinical social worker, advanced practice nurse certified by a national certifying organization in the specialty of psychiatry, or a professional clinical counselor as defined in rule 5101:3-4-29~~ in accordance with the limitations specified in rule 5101:3-28-03 of the Administrative Code.
- (C) ~~Certain services are not considered covered FQHC services. The FQHC's costs for these services are not included in the rates established for "core" and "non-core" services. These services should be billed by an FQHC under~~ Services listed in paragraph (C) of rule 5101:3-28-04 of the Administrative

Code are not FQHC covered services. FQHCs shall bill the department for these services~~a separate Medicaid provider number as a fee-for-service ambulatory care provider as specified~~ in accordance with paragraph (C) of rule 5101:3-28-04 of the Administrative Code.

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MAL 508

**Effective Date: July 1, 2006**

**Most Current Prior Effective Date: March 1, 2002**

(A) ~~Core~~ Covered core medical services for FQHCs are:

- (1) "Physician services," ~~are those services identified~~ as defined in Chapter 5101:3-4 of the Administrative Code. The limitations found in the physician chapter also apply to physician services furnished under the auspices of ~~the federally-qualified health center (FQHC)~~ an FQHC.
- (2) "Physician assistant services," ~~are those services identified~~ as defined in Chapter 5101:3-4 of the Administrative Code. The limitations found in the physician chapter also apply to physician assistant services furnished under the auspices of an FQHC.
- (3) "Advanced practice nurse services," ~~are those services identified~~ as defined in rule 5101:3-8-23 of the Administrative Code, except for services relating to mental health as defined in paragraph (B)(8) of this rule, provided by an advanced practice nurse as defined in rules 5101:3-8-20 to 5101:3-8-23 of the Administrative Code. The limitations found in rule 5101:3-8-23 of the Administrative Code also apply to advanced practice nurse services provided under the auspices of an FQHC.
- (4) "Services and supplies furnished as incident to professional services by a physician, physician assistant, ~~advanced practice nurse, clinical social worker, or psychologist~~" are those services and supplies that are commonly furnished in physicians' offices; and commonly rendered without charge or included in the physician visit charge or provided as an incidental but integral part of the physician's services provided under the direct supervision of a physician as described in paragraph (A)(1) of rule 5101:3-4-02 of the Administrative Code; and, furnished by an employee of the clinic.

(B) ~~Noncore~~ Covered noncore services for FQHCs are:

- (1) "Physical therapy services" are those services identified in rule 5101:3-1-60 of the Administrative Code. These services must be provided in accordance with the physical therapy licensure requirements found in Chapter 4755. of the Revised Code. Limitations found in rule 5101:3-8-02 of the Administrative Code also apply to services rendered in an FQHC.
- (2) "Speech pathology and audiology services" are those services identified in rule 5101:3-1-60 of the Administrative Code. These services must be provided in accordance with the licensure requirements found in Chapter 4753. of the Revised Code. Limitations found in Chapter 5101:3-13 of the Administrative Code also apply to services rendered by an FQHC.
- (3) "Dental services," ~~are those services identified~~ as defined in Chapter 5101:3-5 of the Administrative Code. Limitations found in ~~the dental chapter~~ Chapter 5101:3-5 of the Administrative Code also apply to dental services rendered under the auspices of an FQHC, with the exception of denture services. Full and partial dentures shall be prior authorized by the department. For dates of service on and after the effective date of this rule, FQHCs may submit up to three claims for the provision of dentures, including not more than two follow-up encounters. Follow-up visits shall be medically necessary for the provision of full or partial dentures.
- (4) "Podiatry services" are those services identified in Chapter 5101:3-7 of the Administrative Code. Limitations found in ~~the podiatry chapter~~ Chapter 5101:3-7 of the Administrative Code also apply to podiatry services rendered under the auspices of an FQHC.
- (5) "Optometric and/or optician services" are those services identified in Chapter 5101:3-6 of the Administrative Code. Limitations found in ~~the vision services chapter~~ Chapter 5101:3-6 of the

Administrative Code also apply to vision services rendered under the auspices of an FQHC. Services rendered by an ophthalmologist are physician services and considered a core service.

- (6) "Chiropractic services" are those services identified in ~~rules 5101:3-8-02 and rule~~ 5101:3-8-11 of the Administrative Code. Limitations found in ~~rules 5101:3-8-02, 5101:3-8-03, and rule~~ 5101:3-8-11 of the Administrative Code also apply to chiropractic services rendered under the auspices of an FQHC.
- (7) "Transportation services" are those instances of transportation to and/or from a medicaid service site of an FQHC. The transportation must be provided on the same date ~~as~~ another Medicaid covered encounter occurs.
- (8) "Mental health services" are those services provided by a clinical psychologist or advanced practice nurse certified by a national-certifying organization in the specialty of psychiatry in accordance with Chapter 5101:3-8 of the Administrative Code and services provided by a licensed social worker, of a clinical social worker, professional counselor, professional clinical counselor, and psychology services identified in Chapter 5101:3-8 in accordance with rule 5101:3-4-29 of the Administrative Code. Federally qualified health centers FQHCs shall be able to bill Medicaid for therapy and testing. The limitations found in Chapter 5101:3-8 rules 5101:3-8-05 and 5101:3-4-29 of the Administrative Code also apply to clinical social worker and psychology services provided under the auspices of an FQHC.
- (C) ~~In addition to any service limitations placed on core and noncore services, the provisions~~ Provisions regarding outpatient hospital services identified in rule 5101:3-2-03 of the Administrative Code also apply to ~~federally qualified health centers~~ FQHCs.
- (D) For dates of service on and after January 1, 2006, the Ohio department of job and family services (ODJFS) shall institute a co-payment program under medicaid in accordance with rule 5101:3-1-09 of the Administrative Code. This co-payment program shall also apply to services rendered by an FQHC. Specific information regarding implementation of co-payments in managed care settings are located in Chapter 5101:3-26 of the Administrative Code.

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MAL 508

**Effective Date: July 1, 2006**

**Most Current Prior Effective Date: March 1, 2002**

- (A) "Billable services" for ~~a federally qualified health center (FQHC)~~ FQHCs are ~~those~~ core and noncore services identified in rule 5101:3-28-02 of the Administrative Code ~~which are~~ and provided in accordance with Chapter 5101:3-28 of the Administrative Code.
- (B) Services shall be billed on an encounter basis. An "encounter" is defined as face-to-face contact between a patient and ~~provider~~ provider(s) of covered core or covered noncore services, except for transportation services. ~~The services of a registered nurse shall be billed on a medical encounter basis unless it is provided as "incident to" another medical encounter as described in paragraph (B)(1) of this rule.~~
- (1) FQHC services shall be billed on an encounter basis, in accordance with rule 5101:3-4-02 of the Administrative Code.
- (2) The services of a registered nurse shall be billed as a medical encounter unless provided "incident to" a medical encounter as described in paragraph (B)(3) of this rule.
- ~~(1)~~(3) Encounters with more than one health professional for the same type of service (~~i.e., e.g.,~~ a nurse and a physician provide ~~the same type of service which is~~ a medical service) and multiple ~~encounters~~ interactions with the same health professional that take place on the same day and at a single location constitute a single encounter except when the patient, after the first ~~encounter~~ interaction, suffers illness or injury requiring additional diagnosis and treatment.
- (4) Each type of service, as set forth in paragraphs (A)(1) to (A)(3) and (B) of rule 5101:3-28-03 of the Administrative Code, is separately billable regardless of whether the encounters occur on separate days or the same day (e.g., a physician and a dentist provide different types of services).
- ~~(2)~~(5) "Billable encounters" are ~~the following~~ encounters that:
- (a) ~~Those encounters which take~~ Take place at a service site approved by public health services as part of an FQHC; or
- (b) ~~Those encounters which take~~ Take place in a patient's home or a outpatient hospital setting for the purpose of providing services to FQHC patients; and
- (c) Are documented in the patient health records in accordance with rule 5101:3-1-27 of the Administrative Code.
- (6) For dates of service on and after the effective date of coverage of denture follow-up encounters in accordance with paragraph (B)(3) of rule 5101:3-28-03 of the Administrative Code, to receive reimbursement for a denture follow-up encounter, the FQHC shall submit a claim with the following information:
- (a) Enter the code T1015 modified by U2 to indicate this is a billing for dental services.
- (b) On the next line of the claim, bill D0140 modified by TS to indicate that this is a follow-up visit for a denture service that was previously prior authorized by the department.
- (7) Transportation services shall be billed on a unit basis. Each trip to or from the service site shall be counted as a unit of transportation service.
- (8) Consultations with anyone other than the patient are not considered encounters, and are therefore not billable.
- (9) Each FQHC service site must obtain and use its own separate medicaid provider number.

- (a) An FQHC service site may not use the provider number of another FQHC service site, even another service site within the parent organization.
- (b) Services provided away from the FQHC service site, such as in an individual's home, must be associated with a specific FQHC service site and must be billed using the provider number of the FQHC service site held accountable for the delivery of the services.

~~(C) Encounters with professionals who provide different types of services as set forth in paragraphs (A)(1) to (A)(3) and (B)(1) to (B)(7) and (B)(9) of rule 5101:3-28-03 of the Administrative Code are separately billable regardless of whether the encounter occurs on separate days or the same day (i.e., a physician and a physical therapist provide different types of services).~~

~~(D) Consultations with anyone other than the patient are not billable.~~

~~(E) Transportation services shall be billed on a unit basis. Each trip to or from the service site shall be counted as a unit of transportation service.~~

~~(F)~~(C) The following services are not billable under a provider's FQHC provider number. These services should be billed by an FQHC under a different medicaid provider number as a fee-for-service ambulatory care provider:

- (1) Inpatient hospital surgery;
- (2) Inpatient hospital visits or consultations;
- (3) Medicare crossover claims that are not paid through the automatic medicare crossover process in accordance with rule 5101:3-1-05 of the Administrative Code;
- (4) Disability assistance program claims;
- (5) Take home drugs ~~should~~shall be billed through the pharmacy program as described in Chapter 5101:3-9 of the Administrative Code; and
- (6) Durable medical equipment (DME) for take-home use ~~should~~shall be billed through the DME program as described in Chapter 5101:3-10 of the Administrative Code.

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MAL 508

**Effective Date: July 1, 2006**

**Most Current Prior Effective Date: October 1, 2003**

(A) Definitions:

- (1) "MCP" means a managed care plan, as defined in rule 5101:3-26-01 of the Administrative Code, ~~which reimbursed~~ that reimburses a federally qualified health center (FQHC) for services provided by the FQHC to a medicaid recipient enrolled in the MCP.
- (2) "Encounter" is defined in rule 5101:3-28-04 of the Administrative Code.
- (3) "Enrollee" otherwise known as a member, means each eligible individual enrolled in an MCP as specified in rule 5101:3-26-01 of the Administrative Code.

(B) Effective for services furnished on or after January 1, 2001, FQHCs that have received payment from an MCP for FQHC services identified in rule 5101:3-28-02 of the Administrative Code are eligible to receive a supplemental payment from the department. ~~FQHCs are eligible to receive this payment~~ if the amount the FQHC was paid by an MCP for services provided to an MCP enrollee is less than the amount the FQHC would have received under the ~~cost-based~~ prospective payment system (PPS) reimbursement method described in rule ~~5101:3-28-05~~ 5101:3-28-08 of the Administrative Code.

(C) For services furnished for the period January 1, 2001 to June 30, 2001, FQHCs ~~are~~ were eligible to submit quarterly requests for supplemental payments. ~~Each FQHC may complete the JFS 3454w MCP worksheet as often as quarterly and submit it to the department no longer than one hundred eighty days after the close of the quarter. The following data must be reported:~~

- ~~(1) An FQHC must report all quarterly revenues received from each medicaid MCP for furnishing care to medicaid recipients enrolled with an MCP.~~
- ~~(2) An FQHC must report quarterly encounters as defined in paragraph (A) of this rule, for each category of service established for the FQHC. For example, if the FQHC provided medical, dental, and podiatry services, the number of encounters for each type of service must be reported.~~

~~The department will receive quarterly payment and utilization data from the MCPs and will compare the data submitted by both parties. Should there be a discrepancy between the data submitted by the FQHC and the MCPs, the department will use the lower encounters and the higher revenue figures. FQHCs may submit documentation, e.g. remittance advice detail from the MCP, to confirm the data reported on the JFS 3454w form within thirty days from the date the FQHC received notification from the department of the discrepancy.~~(D) Effective for services furnished on and after July 1, 2001 through September 30, 2003, to receive the supplemental payment for an encounter provided to an MCP enrollee, an FQHC must submit a claim to the department following the Ohio medicaid provider billing instructions utilized by FQHCs for fee-for-service medicaid consumers with third party insurance.

- (1) These billing instructions require an FQHC to report the following on the claim:
  - (a) The ~~local level code (Y0001 through Y0015) which signifies~~ encounter code T1015 and the appropriate modifier to signify the type of encounter provided by the FQHC; and,
  - (b) A detailed CPT code listing reflecting all services provided during the encounter.
- (2) FQHCs seeking supplemental payments must also report the following information on the claim:
  - (a) The third party indicator for the medicaid supplemental payment;
  - (b) The medicaid provider number of the MCP ~~which~~ that paid the FQHC in the referring physician field; and

(c) The sum of the dollar amount the FQHC was paid by any MCP for the service(s) provided to the medicaid recipient listed on the claim minus any incentive payments received from an MCP and any amount received by the FQHC from any other third party insurance.

(E) For services provided on or after October 1, 2003, to receive the supplemental payment, an FQHC must bill for services as outlined in rule 5101:3-28-11 of the Administrative Code. The data elements submitted for a supplemental payment claim are dependent on whether the claim is a paper claim or an electronic transaction:

- (1) If the FQHC chooses to submit a paper claim, submit the data elements outlined in paragraph (D) of this rule except instead of billing the ~~local level~~ codes (~~Y0001 through Y0015~~) to signify the type of encounter, ~~following~~follow the instructions in rule 5101:3-28-11 of the Administrative Code.
- (2) If the FQHC chooses to submit an electronic transaction, use the 837 transaction. Report the data elements unique for supplemental claims:
  - (a) Enter the name of the MCP provider under the "other payer name" field;
  - (b) Enter the "identification code" of the other payer (the MCP) ~~which~~that initially paid for the services. The identification code is assigned by Ohio medicaid; and
  - (c) Enter the sum of the dollar amount the FQHC was paid by the MCP for the services ~~minus~~without regard to the effects of any financial incentive payments (positive or negative) received from the MCP plus any amount received from any other third party insurance. Enter this amount as the "monetary amount" in the "other payer" area.

(F) Calculation of supplemental payments:

- (1) Using the methodology described in paragraph (C) of this rule, the department will pay the FQHC no less frequently than every four months.
- (2) For dates of service on and after July 1, 2001, upon receipt of the claim the department will pay any difference between the amount paid by the MCP to the FQHC and the amount due the FQHC based on ~~their prospective payment~~its PPS rate approved by the department for the specific claim submitted. These payments will occur no less frequently than every four months.

The department's supplemental payment obligation will be determined using the baseline payment that the FQHC would have received under ~~prospective payment~~PPS reimbursement as described in rule 5101:3-28-08 of the Administrative Code without regard to the effects of any financial incentives (positive or negative) received from the MCP that are linked to utilization outcomes or other reductions in patient costs.(G) If a claim is not submitted by an FQHC to the department within the standard time frames ~~specified~~required for claims submission ~~specified~~in accordance with rule 5101:3-1-19.3 of the Administrative Code, no supplemental payment(s) will be made by the department to the FQHC.

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**MAL 508**

**Effective Date: July 1, 2006**

**Most Current Prior Effective Date: October 25, 2001**

(A) Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 requires states to establish a ~~new~~ medicaid prospective payment system (PPS) for FQHCs. This rule addresses how the department ~~will comply~~complies with BIPA requirements.

~~(B) Definitions:~~

~~(1) "Change in scope of service" means that the addition or deletion of a new category of service or the department has granted a request filed by an FQHC that a service has changed in scope as specified in paragraph (B) of rule 5101:3-28-09 of the Administrative Code.~~

~~(2) "Category of service" means the following different types of services:~~

~~(a) Medical;~~

~~(b) Dental;~~

~~(c) Mental health specifically services of a clinical psychologist or clinical social worker;~~

~~(d) Physical therapy;~~

~~(e) Podiatry;~~

~~(f) Optometry;~~

~~(g) Chiropractic;~~

~~(h) Speech therapy and audiology; and~~

~~(i) Transportation.~~

~~(3) "Increase or decrease in the scope of services" means the addition or deletion of a new category of service or the department has granted a request filed by an FQHC that a service has changed in scope as specified in paragraph (B) of rule 5101:3-28-09 of the Administrative Code.~~

~~(C)~~(B) Cost report filing provisions are specified in rule 5101:3-28-10 of the Administrative Code.

~~(D) Phase one of the new medicaid PPS system~~

~~For dates of service January 1, 2001 through September 30, 2001 (the first phase of the new prospective payment system) the department will pay current FQHCs one hundred per cent of the average of their costs for providing medicaid-covered services during calendar year 1999 and calendar year 2000 (i.e., FQHC medicaid program fiscal year) which are reasonable and related to the costs of furnishing services. The determination of reasonable and related costs are based on tests of reasonableness as defined in paragraph (H) of this rule and paragraphs (D), (E), (F), and (H)(2)(a) and (H)(2)(b) of rule 5101:3-28-05 of the Administrative Code(1)~~

~~The department will use the cost-based interim rates established from the rate methodology described in paragraph (H) of this rule and rule 5101:3-28-05 of the Administrative Code) for calendar year 1999 and calendar year 2000 and take the average of these rates for each FQHC to arrive at the prospective payment system (PPS) base rates by category of service for each FQHC for January 1, 2001 through September 30, 2001. Base PPS rate(s) shall be the term used for the initial PPS rate(s) assigned to an FQHC.~~

~~(2) The resulting average rate will be adjusted, if necessary, to take into account any increase or decrease in the scope of services as defined in paragraph (B) of this rule furnished during calendar year 2001 by the FQHC. The rate setting methodology described in paragraph (A) of~~

~~rule 5101:3-28-09 of the Administrative Code will be used to establish the rate for the service which has changed in scope.~~

~~(E) FQHCs will receive payments for the period January 1 through September 30, 2001 based on their new prospective payment system rates retroactively. Until the base prospective payment system rates are established, providers will continue to be paid using the interim rates set for state fiscal year 2001.~~

~~(F)(C) Beginning on October 1, 2001, and on~~ On October first of each year ~~thereafter, the following procedures will occur:~~

- (1) All ~~prospective payment system~~ PPS rates in effect on September thirtieth will be inflated by the percentage increase in the latest available medicare economic index (MEI) ~~for primary care services;~~
- (2) The department will calculate the sixtieth percentile for urban and for rural FQHCs. The most recently calculated sixtieth percentile will be used for any rate assignments occurring from October first and through September thirtieth due to changes in scope of service as described in paragraph ~~(A)(B)~~ of rule 5101:3-28-09 of the Administrative Code or for the start-up rate for newly-qualified FQHCs; and
- (3) The transportation payment value in effect on September thirtieth will be inflated by the percentage increase in the latest available ~~medicare economic index (MEI)~~ MEI for primary care services. The most recently calculated transportation value will be used for any rate assignments occurring from October first through September thirtieth.

~~(G)(D)~~ Newly-qualified FQHCs.

- (1) Newly qualified FQHCs as specified in rule 5101:3-28-01 of the Administrative Code ~~after state fiscal year 2002~~ will have their base PPS rate(s) set based on the rates established for other FQHCs in the nearest adjacent area ~~which~~ that are similar in size, caseload, and scope of services. If there is no FQHC in the nearest adjacent area ~~which~~ that is similar in size, caseload, and scope of services, the state-wide urban or state-wide rural sixtieth percentile rate(s) in accordance with paragraph ~~(F)(C)~~(2) of this rule will be assigned to the newly-qualified FQHC as the start-up PPS rate(s).
- (2) After the start-up rate is set, the following procedures will occur:
  - (a) The newly-qualified FQHC will file a cost report in accordance with paragraph (B)(1) of rule 5101:3-28-10 of the Administrative Code;
  - (b) Base rate(s) for the newly qualified FQHCs will be set based on their newly-qualified FQHC's costs reported on the cost report and based on the principles described in paragraphs ~~(A)(3)(B)(3)~~ to ~~(A)(7)(e)(B)(7)(e)~~ of rule 5101:3-28-09 of the Administrative Code;
  - (c) The start-up rate(s) will be adjusted. The new PPS base rate will be the ~~cost-based~~ rate established using the principles described in paragraphs ~~(A)(3)(B)(3)~~ to ~~(A)(7)(e)(B)(7)(e)~~ of rule 5101:3-28-09 of the Administrative Code adjusted by any MEI increases ~~which~~ that may have occurred since the filing of the FQHC's cost report.
  - (d) The rate will be effective within sixty days of receipt of a complete and accurate cost report.
- (3) The wage index for urban areas or the wage index for rural areas used to establish the rate(s) for newly-qualified FQHCs shall be the most recent ~~wage~~ index applicable to the newly-qualified FQHC's location published in the ~~federal register~~ Federal Register for the year in which the new FQHC is eligible to become an ~~ohio~~ Ohio medicaid provider.
- (4) In future years, the PPS rate(s) will be adjusted by the MEI in accordance with paragraph ~~(F)(C)~~ of this rule.

(E) Each FQHC service site must obtain its own PPS rate for each type of service provided. An FQHC service site may not use a PPS rate of another service site to bill medicaid.

- (H) ~~The provisions of rule 5101:3-28-05 of the Administrative Code shall apply to establishment of the base prospective payment rates as described in paragraph (D) of this rule with the following exceptions:~~
- ~~(1) Annual cost report filing as stated in paragraph (G) of 5101:3-28-05 of the Administrative Code will not be required except for:
    - ~~(a) FQHCs adding a new category of service;~~
    - ~~(b) Newly qualified FQHC sites; or~~
    - ~~(c) FQHCs which request and are granted a change in scope of service as described in paragraph (B) of rule 5101:3-28-09 of the Administrative Code.~~~~
  - ~~(2) The provisions in paragraphs (H)(4) to (H)(5) of rule 5101:3-28-05 of the Administrative Code addressing interim settlements shall not apply.~~
  - ~~(3) The provisions in paragraph (I) of rule 5101:3-28-05 of the Administrative Code addressing audits and final settlements shall not apply.~~
  - ~~(4) The ceiling on administrative and general costs described in paragraph (E) of rule 5101:3-28-05 of the Administrative Code shall be increased to thirty-five per cent.~~
  - ~~(5) The wage index described in paragraph (H)(2) of rule 5101:3-28-05 of the Administrative Code used to establish the baseline rates will be the most recent wage index published in the federal register for the year 2000.~~
  - ~~(6) Instead of the "statewide urban mean" and the "statewide rural mean" described in paragraphs (H)(2)(a) and (H)(2)(b) of rule 5101:3-28-05 of the Administrative Code the department will use the sixtieth percentile for urban FQHCs and the sixtieth percentile for rural FQHCs.~~
  - ~~(7) The test of reasonableness for transportation services shall be increased to twenty dollars per one-way unit of service to and/or from a medicaid covered FQHC service.~~

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**MHTL 3354-12-01**

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This rule describes an alternate payment method (APM) that may be selected, with approval from the department, by an FQHC operated by a state or local governmental entity (a "government-operated FQHC"). This APM applies only to FQHC services included in cost reports submitted on or after July 1, 2011.

- (A) Within one hundred twenty days after the close of a fiscal year, the government-operated FQHC must use a "Federally Qualified Health Center / Outpatient Health Facility Cost Report," form [JFS 03421](#) (rev. 07/2001), to compile and submit an initial cost report of all services delivered during that fiscal year. A government-operated FQHC that has more than one service site must submit separate cost reports for the individual sites.
- (B) When it submits an initial cost report, the government-operated FQHC must certify to the department that its costs were an expenditure of public funds not derived from a federal funding source and not otherwise used as a state or local match for federal funds.
- (C) After it receives a complete and accurate initial cost report and certification, the department will perform a desk audit of the cost report and determine the amount for which the government-operated FQHC is eligible to receive federal matching funds.
- (1) No additional limitation, test of reasonableness, or ceiling described in rule [5101:3-28-09](#) of the Administrative Code is applied to the initial cost report. The resulting figures represent the total actual allowable costs during the fiscal year.
- (2) From these figures, the "average cost per visit" for each FQHC service offered at the site is obtained by dividing the total allowable cost for the service by the total number of visits.
- (3) For each FQHC service, the "total allowable medicaid cost" for the fiscal year is the product of the average cost per visit and the number of visits made by medicaid-eligible individuals.
- (4) The "total medicaid reimbursement" for an FQHC service during a fiscal year is the sum of reimbursement amounts received by an FQHC under the prospective payment system (PPS), payments made by medicaid managed care plans, and managed care supplemental ("wraparound") payments made by the department.
- (5) If the total allowable medicaid cost for an FQHC service exceeds the total medicaid reimbursement, then the department will calculate the federal share of the difference (the "medicaid gap") by applying the appropriate federal match percentage. The department will then remit the federal share for each FQHC service to the government-operated FQHC. This payment is a supplement to, not a substitute for, the total medicaid reimbursement defined in paragraph (C)(4) of this rule.
- (D) Within five hundred days after the close of a fiscal year, the government-operated FQHC must use form JFS 03421 to submit a fully audited cost report of all services delivered during that fiscal year. A government-operated FQHC that has more than one service site must submit separate cost reports for the individual sites. From the audited cost report, the department will follow the procedure described in paragraph (C) of this rule to calculate the federal share of the medicaid gap for each FQHC service offered by the government-operated FQHC. If the federal share of the medicaid gap based on the initial cost report is greater than the federal share of the medicaid gap based on the fully audited cost report, then the government-operated FQHC must remit the difference to the department within thirty days; if it is less, then the department must remit the difference to the government-operated FQHC. For payment purposes, the federal share amounts for the various FQHC services offered at a single site may be aggregated.

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5160-28-09 Federally Qualified Health Centers (FQHCs): Prospective Payment System (PPS) Rate Review for Change in Scope of Service

~~\*Formerly\*~~ 5101:3-28-09 Federally Qualified Health Centers (FQHCs): Prospective Payment System (PPS) Rate Review for Change in Scope of Service

MAL 508

**Effective Date: July 1, 2006**

**Most Current Prior Effective Date: October 25, 2001**

~~Paragraphs (A) and (B) of this~~ This rule ~~describe~~ describes the two methods for ~~making adjustments for changes in scope of~~ determining PPS rates for a change in scope of service ~~provided by an FQHC provider site as part of the prospective payment system~~ (A) Definitions.

- (1) "Change in scope of service" means:
  - (a) The addition or deletion of a new category of service as described in paragraph (B) of this rule; or
  - (b) The department has granted a request filed by an FQHC that a service has changed in scope as specified in paragraph (C) of this rule.
- (2) "Category of service" means the following different types of services:
  - (a) Medical, as defined in Chapter 5101:3-4 of the Administrative Code;
  - (b) Dental, as defined in Chapter 5101:3-5 of the Administrative Code;
  - (c) Mental health, as defined in rule 5101:3-8-05 and 5101:3-4-29 of the Administrative Code;
  - (d) Physical therapy, as defined in rule 5101:3-8-02 of the Administrative Code;
  - (e) Podiatry, as defined in Chapter 5101:3-7 of the Administrative Code;
  - (f) Optometry, as defined in Chapter 5101:3-6 of the Administrative Code;
  - (g) Chiropractic, as defined in Chapter 5101:3-11 of the Administrative Code;
  - (h) Speech pathology and audiology, as defined in Chapter 5101:3-13 of the Administrative Code; and
  - (i) Transportation, as defined in Chapter 5101:3-15 of the Administrative Code.
- (3) "Increase or decrease in the scope of services" means the addition or deletion of a category of service or the department has granted a request filed by an FQHC that a service has changed in scope as specified in paragraph (C) of this rule.

~~(A)~~(B) Method one:

A routine change in scope of service is the addition or deletion of a new category of service as defined in paragraph ~~(B)~~(A) of ~~this rule 5101:3-28-08 of the Administrative Code~~ The following methodology will be used to establish the rate for a service type ~~which~~that meets the provisions in paragraph ~~(B)~~(A)(1)(a) of ~~this rule 5101:3-28-08 of the Administrative Code~~ (1) As an interim step, FQHCs ~~which~~that establish a new category of service will be given a start-up rate for the new category of service. The start-up rate for urban FQHCs will be the sixtieth percentile for urban FQHCs offering that category of service in accordance with paragraph ~~(F)~~(C) of rule 5101:3-28-08 of the Administrative Code. For rural FQHCs, the ~~startup~~start-up rate will be the sixtieth percentile for rural FQHCs offering that category of service in accordance with paragraph ~~(F)~~(C) of rule 5101:3-28-08 of the Administrative Code. This interim rate will be in effect until a rate for that FQHC for that category of service is established by the department based on the methodology described in paragraphs ~~(A)(3)~~(B)(3) to ~~(A)(7)~~(B)(7) of this rule.

- (2) ~~As stated in paragraph (C) of rule 5101:3-28-08 of the Administrative Code, any~~ FQHCs adding a new category of service must file ~~two~~a cost ~~reports~~report in accordance with the instructions

~~specific~~ in JFS 03421 (07/2001) and ~~within the time frames stated in paragraph (C) of rule 5101:3-28-08~~rule 5101:3-28-10 of the Administrative Code:

- ~~(a) A cost report must be filed for the twelve month period beginning on the first day of the first full month after the new category of service was added began operation; and~~
- ~~(b) A cost report must be filed for the twelve month period beginning on the first day of the first full month before the new category of service was added began operation.~~
- (3) Upon receipt of a complete and accurate cost report, the department will review the FQHC's costs for the service ~~which~~that has changed in scope of service and will adjust the ~~prospective payment system~~PPS rate based on the reasonable cost parameters described in paragraphs ~~(A)(4) to (A)(7)~~(B)(4) to (B)(7) of this rule.
- (4) General provisions for allowable and reasonable costs.

"Costs ~~which~~that are reasonable and related to patient care" are those contained in the following reference material in the following priority: "42 CFR Part C.F.R. part 413 "principles of reasonable cost reimbursement" effective October 1, 2005; "health insurance manual 15-1 provider reimbursement manual," "centers for medicare and medicaid services (CMS) publication 15-1, provider reimbursement manual," available at [www.cms.hhs.gov/manuals/](http://www.cms.hhs.gov/manuals/) (rev. 1/2005); and "generally accepted accounting principles" "the American institute of certified public accountants (AICPA) Federal generally accepted accounting principles (GAAP) hierarchy statement on auditing standards (SAS) No. 91 (1999),"" except that:

- (a) Costs related to patient care and services that are not covered under the FQHC program as described in Chapter 5101:3-28 of the Administrative Code are not allowable.
- (b) The straight line method of computing depreciation is required for cost filing purposes, and it must be used for all depreciable assets.
- (c) For purposes of determining allowable and reasonable cost in the purchase of goods and services from a related party, the following definition of related shall be used: "related" is one who enjoys, or has enjoyed within the previous five years, any degree of another business relationship with the owner or operator of the facility, directly or indirectly, or one who is related by marriage or birth to the owner or operator of the facility.
- (d) Upper limits for costs associated with related party transactions are defined as the following:
  - (i) FQHCs are required to identify all related organizations; i.e., related to the FQHC by common ownership or control.
  - (ii) The cost claimed on the cost report for services, facilities, and supplies furnished by the related organization shall not exceed the lower of:
    - (a) The cost to the related organization; or
    - (b) The price of comparable services, facilities, or supplies generally available.
- (e) Tests of reasonableness, ceilings and upper limits as identified in paragraphs ~~(A)(5) to (A)(7)~~(B)(5) to (B)(7) of this rule shall be applied in determining allowable and reasonable cost.
- (5) Ceilings on administrative and general costs.
  - (a) A thirty-five per cent ceiling for total allowable administrative and general and overhead costs shall be applied to all services. Total allowable administrative and general and overhead costs are defined as costs reported on the JFS 03421, schedule C-1, part II and schedule C-2 parts III and IV, plus any allowable costs to these costs areas from schedule C-1, part I of the JFS 03421.

- (b) An annual exemption of thirty thousand dollars per year per provider from the ceiling on administrative and general costs is allowable for the recruitment costs of core providers.

(6) Tests of reasonableness for professional services and transportation.

Allowable costs reported to the department in accordance with the instructions for the JFS 03421 will be adjusted based on minimum required efficiency standards calculated as encounters per hour. The rate established for the following service components will not exceed the lower of the rates as determined by dividing allowable costs by allowable encounters or allowable costs divided by the product of direct hours worked by the professional and the encounters per hour as shown ~~below~~

- (a) Physician services - 2.4 encounters per hour per physician;
- (b) Physician assistant or advanced practice nurses services - 1.2 encounters per hours per practitioner;

- (c) ~~Clinical social worker and psychology~~ Mental health services in accordance with paragraph (B)(8) of rule 5101:3-28-02 of the Administrative Code --.7 encounters per hour;

- (d) Physical therapy services -- 2.0 encounters per hour;

- (e) Speech pathology and audiology services -- 1.8 encounters per hour;

- (f) Dental services -- 1.8 encounters per hour;

- (g) Podiatry services -- 2.4 encounters per hour;

- (h) ~~Optometric/optician~~ Optometric and/or optician services -- 2.3 encounters per hour; and

- (i) Chiropractor services -- 2.4 encounters per hour; and

- (j) Transportation reimbursement shall not exceed: twenty-five dollars per one way unit of service to and/or from a medicaid covered FQHC service.

- (i) ~~Twenty-five dollars for dates of service prior to October 1, 2001; and~~

- (ii) ~~For dates of service on or after October 1, 2001, the transportation value derived by performing the calculation described in paragraph (F)(3) of rule 5101:3-28-08 of the Administrative Code per one way unit of service to and/or from a medicaid covered FQHC service.~~

(7) Reimbursement rates shall not exceed the higher of the appropriate medicare ceiling or the wage adjusted ceilings on reimbursement rates as follows: ~~ceilings on reimbursement rates as follows:~~

- (a) Using as filed the JFS 03421 for each eligible FQHC site, an allowable cost per encounter for any new category of service shall be calculated. Tests of reasonableness, ceilings, and upper limits identified in paragraphs ~~(A)(5) to (A)(7)~~ (B)(5) to (B)(7) of this rule shall be applied to the as filed cost of each eligible FQHC site prior to calculation of the percentile cost per encounter.

- (b) The statewide urban sixtieth percentile cost per encounter is the sixtieth percentile of the values of all urban ~~facilities'~~ facilities receiving a grant under section ~~329, 330, or 340~~ of the Public Health Service Act in accordance with paragraph ~~(F)(C)~~ of rule 5101:3-28-08 of the Administrative Code. The statewide rural percentile cost per encounter is the sixtieth percentile of the values of all rural ~~facilities'~~ facilities receiving a grant under section ~~329, 330, or 340~~ of the Public Health Service Act in accordance with paragraph ~~(F)(C)~~ of rule 5101:3-28-08 of the Administrative Code.

- (c) The urban wage adjustment factor is the adjustment factor for the FQHC's location obtained from the most recent Ohio wage index published in the ~~federal register~~ Federal Register for the year in which the FQHC's rate is being established divided by the most recent Ohio rural wage index.

(d) The final ceilings on core and noncore service reimbursement for each rural facility is the statewide rural sixtieth percentile as set forth in paragraph ~~(A)(7)(b)~~(B)(7)(b) of this rule. The final ceilings on core and noncore service reimbursement for each urban facility is calculated by multiplying the statewide urban sixtieth percentile as set forth in paragraph ~~(A)(7)(b)~~(B)(7)(b) of this rule by the adjustment factor for the FQHC's wage adjustment factor described in paragraph ~~(A)(7)(e)~~(B)(7)(c) of this rule.

~~(e) The payment rate shall not exceed the higher of the medicare ceiling or the wage adjusted ceilings for reimbursement rates as set forth in paragraph (A)(7)(d) of this rule.~~

(e) The payment rate shall not exceed the higher of the medicare ceiling or wage adjusted ceilings for reimbursement rates as set forth in paragraph (B)(7)(d) of this rule.

(f) The final rate for the service ~~which~~that has changed in scope of service will be effective within sixty days of receipt of a complete and accurate cost report.

~~(B)(C)~~ Method two:

An FQHC also may request a review for a change in scope of service if none of the provisions in paragraph ~~(B)(A)~~ of this rule ~~5101:3-28-08 of the Administrative Code~~ apply.(1) A change in scope of service may include but is not limited to the following:

(a) The addition of a service ~~which~~that has been mandated by a governmental entity such as the ~~health resource services administration (HRSA)~~the centers for medicare and medicaid services (CMS) in federal statute, rules, or policies enacted or amended after January 1, 2002;

(b) The addition of an obstetrical-gynecological physician or nurse mid-wife or other advanced practice nurse with a certification in obstetrical-gynecological services to an FQHC site ~~which~~that did not previously offer obstetrical services;

(c) The addition of a dentist to a site ~~which~~that only offered dental hygienist's services previously. The site did not previously employ a licensed dentist and did not offer the full scope of dental services; or

(d) An increase in the intensity of services provided.

(2) The following situations ~~would not be considered~~are not considered a change in scope of services:

(a) Wage increases;

(b) Negotiated union contracts;

(c) Renovations or other capital expenditures;

(d) The addition of a disease management program;

(e) An increase in the number of staff working in the clinic such as the addition of:

(i) A lower level staff member such a family nurse practitioner when a site employs a family physician;

(ii) A hygienist when a dentist is employed at the site;

(iii) A ~~physician~~physical therapy assistant when the site employs a physical therapist; and

(iv) Social service staff;

(f) An increase in office space ~~which~~that is not directly associated with an approved change in scope of service, e.g., the addition of an obstetrical-gynecological physician;

- (g) An increase in equipment or supplies ~~which~~that is not directly associated with an approved change in scope of service, e.g., the addition of an obstetrical-gynecological physician;
  - (h) An increase in patient volume; and
  - (i) An increase in office hours.
- (3) An FQHC's request for a rate increase due to a change in scope of service will be granted at the sole discretion of the department. The calculated ~~cost-based~~PPS rate for the ~~service~~ ~~which~~that changed in scope must increase by at least twice the MEI for that year before the department will grant the request for a change in scope of service.
- (4) A rate review for a change in scope of service shall not increase a rate in excess of any rate limitations, ceilings, or tests of reasonableness set forth in division-level ~~designation~~-5101:3 of the Administrative Code.
- (5) A request for review of a change in scope of service must be filed no later than ninety days after the close of one year of operation of the service ~~which~~that has changed in scope.
- (6) A rate adjustment due to a change in scope shall be granted only once for a particular circumstance for a particular FQHC.
- (7) A request for rate review due to a change in scope of service must be filed in accordance with the following procedures:
- (a) The request for review of a change in scope of service must be in writing~~;~~;
  - (b) The request for a rate review must indicate that it is due to a change in scope of service~~;~~;
  - (c) The request for a rate review must provide a detailed explanation and evidence to prove why a rate adjustment is warranted. The FQHC should demonstrate that by providing either:
    - (i) A community needs assessment shows that population demographic changes warrant the change in scope of service; or
    - (ii) A business plan or other similar documentation indicates that the new service is warranted; and
    - (iii) Efforts were made to address the problem outside of the rate review process.
  - (d) If the request is due to a change in the intensity of services provided, the FQHC must provide evidence that the intensity of services has changed and that the increased costs are directly related to the change in intensity of service. This evidence might include a report showing that patients' diagnoses have changed the acuity of care or a report proving that the relative values of the services provided has changed.
  - (e) The FQHC must file two complete cost reports as specified in rule 5101:3-28-10 of the Administrative Code ~~which~~that include all schedules and attachments specified for the JFS 03421 cost report and documentation supporting the cost increase. The FQHC must specify in ~~their~~its written request exactly what cost centers in the cost report have been impacted by the increased costs for the service ~~which~~that has changed in scope and why they were impacted. Failure to file the cost reports within the time period described in paragraph (A)(3) of rule 5101:3-28-10 of the Administrative Code will mean that the department will not evaluate the request for consideration of a change in scope.
    - ~~(i) A cost report must be filed for the twelve-month period beginning on the first day of the first full month after the service which has changed in scope began operation;~~
    - ~~(ii) A cost report must be filed for the twelve-month period beginning on the first day of the first full month for the twelve-month period before the service which has changed in scope began operation;~~

- ~~(iii) The cost reports and all required documents listed in paragraph (B)(7) of this rule must be filed within ninety days after the close of the first twelve months of operation of the service which has changed in scope; and~~
- ~~(iv) Failure to file the cost reports within the time period described in paragraph (B)(7)(e)(iii) of this rule, will mean that the department will not evaluate the request for consideration of a change in scope.~~

- (8) The department shall respond in writing within sixty days of receiving each written request for a change in scope of service. If the department requests additional information to determine if the rate request is warranted, the department shall respond in writing within sixty days of receiving the additional information.
- (9) If a request for a rate adjustment due to a change in scope of service is granted, the following provisions will apply:
  - (a) The department will review the FQHC's costs for the service which~~that~~ has changed in scope and will set a rate based on the reasonable cost parameters described in paragraphs ~~(A)(4) to (A)(7)~~(B)(4) to (B)(7) of this rule.
  - (b) The rate increase shall be the difference between the new rate calculated for the service which~~that~~ has changed in scope ~~submitted on the cost report described in paragraph (B)(7)(e)(i) of this rule~~ minus the rate previously calculated for the prior year for that category of service ~~described in paragraph (B)(7)(e)(ii) of this rule~~. The rate increase amount shall be added to the current year's prospective payment~~PPS~~ rate for that specific category of service for the FQHC.
  - (c) The rate described in paragraph ~~(B)(9)(b)~~(C)(9)(b) of this rule shall be inflated by the MEI in accordance with paragraph ~~(F)(C)~~ of rule 5101:3-28-08 of the Administrative Code.
  - (d) The rate adjustment shall be effective on the first day of the first full month after the department has granted the request. Retroactive adjustments will not be made.

~~(C)~~(D) The department's decision at the conclusion of the rate review process shall not be subject to any administrative proceedings under Chapter 119. of the Revised Code.

~~(D)~~(E) An ~~fqhc~~FQHC must notify the department in writing within ninety days of any permanent decrease in a scope of service.

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MAL 508

**Effective Date: July 1, 2006**

**Most Current Prior Effective Date: October 25, 2001**

- (A) If the following situations apply to an FQHC, ~~the~~ a JFS 03421 (rev. 07/2001) cost ~~report~~report(s) must be filed with the department:
- (1) An entity is newly-qualified as an FQHC on or after July 1, 2001 as described in rule 5101:3-28-01 of the Administrative Code;
  - (2) An existing FQHC has added a service ~~which~~that has changed in scope because the FQHC began providing a new category of service as defined in paragraph (B)~~(1)~~ of rule ~~5101:3-28-08~~5101:3-28-09 of the Administrative Code; ~~or~~and
  - (3) An FQHC has requested that the department review a request for a change in scope of service as described in paragraph ~~(B)~~(C) of rule 5101:3-28-09 of the Administrative Code.
- (B) Filing requirements
- (1) If a cost report is required because the FQHC meets the condition described in paragraph (A)(1) of this rule, the cost report must be filed within ninety days after the close of one full year of operation of the new FQHC. The cost report shall be filed in accordance with the instructions specified for the JFS 03421 and must cover the period beginning the first day of the first full month after the new FQHC became qualified as an FQHC.
  - (2) If a cost report is required because the FQHC has added a new category of service as described in paragraph (A)(2) of this rule, the cost report shall be filed within ninety days after the close of one full year of operation of the new FQHC. The cost report shall be filed in accordance with the instructions specified for the JFS 03421 and shall cover the period beginning on the first day of the first full month after the new category of services was added.
  - ~~(2)~~(3) If cost reports are required because the FQHC meets the ~~conditions~~condition described in paragraph ~~(A)(2) or (A)(3)~~ of this rule, two cost reports must be filed ~~in accordance with the instructions specified for the JFS 03421. The provisions for filing these two cost reports are described in paragraphs (A)(2) and (B)(7) of rule 5101:3-28-09 of the Administrative Code.~~
    - (a) The first cost report shall be filed in accordance with the instructions specified for the JFS 03421 and shall cover the twelve month period ending the last day of the last month before the service changed in scope and shall be submitted to the department, with all required documentation, within ninety days after the close of the twelve month period.
    - (b) The second cost report shall be filed in accordance with the instructions specified for the JFS 03421 and shall cover the twelve month period beginning on the first day of the first full month after the service that has changed in scope began operation and shall be submitted to the department with all required documentation within ninety days after the close of the twelve month period.
- (C) Failure to file complete and accurate cost reports within the time frames established in paragraph (B) of this rule will result in the department making no adjustments to the rate(s) for a service ~~which~~that the FQHC claims has changed in scope of service. No extensions will be granted for cost report filings.
- (D) The cost report form, JFS 03421, to be submitted by the FQHC shall be supplied by the department. The FQHC must request ~~the computer diskette containing~~ the cost report software from the department by contacting the manager of financial operations within the bureau of health plan policy in the office of medicaid. ~~A hard copy of this cost report and report instructions are attached as appendix (A) to this rule.~~

(E) The FQHC must complete and return ~~the computer diskette containing~~ the cost report to the department within the time frames stated in paragraph (B) of this rule. ~~A paper copy of the completed cost report shall accompany the completed diskette version of the FQHC's cost report.~~

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- ~~(A)~~ For services provided prior to October 1, 2003, follow the standard medicaid billing instructions at web site <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> (01/03).
- ~~(B)~~ For services provided on or after October 1, 2003, follow the latest billing instructions at web site <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> (10/03) applicable for services provided on and after that date. The FQHC may choose to submit a paper claim or an electronic transaction:
- ~~(1)~~ If the FQHC chooses to submit a paper claim, the FQHC must submit the standard professional claim form; or
  - ~~(2)~~ If the FQHC chooses to submit an electronic transaction, the FQHC must submit the electronic format recognized by the department in accordance with the department's billing instructions (10/03).
- ~~(C)~~(A) For services provided on or after October 1, 2003, ~~submit~~FQHCs shall include the following data elements unique for FQHC billings:
- ~~(1)~~ Enter theThe code T1015;\_
  - ~~(2)~~ Modify theThe code to specify the type of encounter provided, e.g., T1015U1:
    - (a) For a medical encounter, use the modifier U1;
    - (b) For a dental encounter, use the modifier U2;\_
    - (c) For a mental health encounter, use the modifier U3;
    - (d) For a physical therapy encounter, use the modifier U4;
    - (e) For a speech ~~therapy~~pathology encounter, use the modifier U5;
    - (f) For a podiatry encounter, use the modifier U6;
    - (g) For ~~a vision~~an optometric and/or optician services encounter, use the modifier U7;
    - (h) For a chiropractic encounter, use the modifier U8; and
    - (i) For a transportation encounter, use the modifier U9.
  - ~~(3)~~ Enter all theAll procedure codes ~~which~~that describe the services provided during the encounter.
- ~~(D)~~(B) If the services is provided on ~~and~~or after October 1, 2003, and the claim is for a supplemental payment, follow the applicable instructions found in this rule addressing coding and modifiers. In addition, submit the unique data elements required for a supplemental payment found in rule 5101:3-28-07 of the Administrative Code.
- (C) For consumers in the medicaid managed care program, claims submission requirements, including prior authorization requests for FQHC services as defined in Chapter 5101:3-28 of the Administrative Code are specified in rules 5101:3-26-03.1 and 5101:3-26-05.1 of the Administrative Code.

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## **Notice**

A Federally Qualified Health Centers provider handbook is not currently available. However, when a Medical Assistance Letter (MAL) is issued, regarding Federally Qualified Health Centers, it will be posted here.