Chapter 21

Medicaid Provider Manual

Federally Qualified Health Centers

March 2016

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21.1 GENERAL

21.1.1 Descriptions

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are providers that meet the criteria of a FQHC or FQHC look-alike (referred to as FQHC for the remainder of this chapter) or of a RHC (collectively referred to as FQHC/RHC), as defined by the United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS). They are differentiated from other fee-for-service Medicaid providers in several ways:

- They must receive a designation from the federal government as a FQHC/RHC;
- They have a unique definition of services that qualify as FQHC/RHC services; and
- They are reimbursed using a Prospective Payment System (PPS) methodology.

21.1.2 Becoming a Medicaid Provider in Hawaii

All providers rendering services in a FQHC/RHC must be licensed to perform services in the state of Hawaii. Credentialing and verification of licensing is the responsibility of the FQHC/RHC.

21.1.3 Receiving Designation as a FQHC/RHC

In order to receive designation as a FQHC/RHC under the Hawaii Medicaid program, providers must meet the requirements as listed in 42 CFR 405.2401 (b). This includes receiving a grant under Sections 329, 330 or 340 of the Public Health Services Act or receiving funding from a client of a grant. In addition, other non-profit organizations that are determined by the Secretary of DHHS to meet the requirements for receiving such a grant may qualify as a FQHC look-alike provider. Such determination is made based on the recommendation of DHHS Health Resources Services Administration (HRSA). In addition to the Provider Information Form (DHS 1139), providers wishing to receive the designation of a FQHC/RHC in the Hawaii Medicaid program must submit a copy of their grant letter or other documentation from DHHS showing eligibility. If a provider does not submit this information, they will not receive the designation of FQHC/RHC.

21.2 FQHC SERVICES

21.2.1 Providers Who May Provide PPS Eligible Services

FQHC services shall be delivered exclusively by the following health care professionals who are licensed in Hawaii and residents of the State of Hawaii:

- Doctor of Medicine (MD);
- Doctor of Osteopathy (DO);
- Doctor of Dentistry (DDS, DMD);
- Doctor of Optometry (OD);
- Doctor of Podiatry (DPM);
- Physician's assistant (PA);
- Nurse practitioner (advance practice registered nurse (APRN);
- Certified nurse midwife (APRN with subcategory);
- Visiting nurse (A visiting nurse is a resident of Hawaii who is a licensed registered nurse, licensed practical nurse, or licensed vocational nurse that is employed by or receives compensation for the services from a FQHC.);
- Clinical social worker (LCSW);
- Clinical psychologist (PhD, PsyD); or
- Licensed dietitian (LD)

The health care professionals listed above are FQHC covered professionals when they provide services within their scopes of practice. Services provided by health care professionals other than those listed above, even if under the supervision of FQHC covered health care professionals, are not FQHC covered services and are not eligible for PPS reimbursement.

21.2.2 Covered Services Eligible for PPS Reimbursement

Services eligible for PPS reimbursement (FQHC PPS Services) must be:

- Within the legal authority of a FQHC or RHC to deliver, as defined in Section 1905 of the Social Security Act as amended;
- Actually provided by the FQHC or RHC, either directly or under arrangements;
- Medicaid covered ambulatory services under the Medicaid program, as defined in the Hawaii Medicaid State Plan;
- Within the scope of services provided by the State under its fee-for-service and Medicaid Quest Integration program.
- Provided to a recipient eligible for Medicaid benefits;
- Delivered exclusively by the licensed health care professionals listed in section 21.2.1 who are residents of Hawaii; and

- Provided in an outpatient setting during business or after hours on the FQHC's or RHC's site.

For Full-benefit dual eligibles (FBDE), also called Qualified Medicare Beneficiaries Plus (QMBPlus) FQHC PPS Services may be provided at the patient's place of residence, which may be a skilled nursing facility, a nursing facility, domiciliary home, foster home, or other institution used as a patient's home, within the limitation noted below:

  - For FQHC PPS Services that are covered under Medicare and Medicaid, payments will be paid first by Medicare and the difference by Medicaid, up to the State's PPS payment limit.

Services and supplies that are defined as "Incident to" by Medicare are included in the all-inclusive PPS rate. See MLN Matters Number: SE0441 for a complete definition of "Incident to" services.

Ancillary services performed by a FQHC in a clinic setting including laboratory, ultrasound, and radiology are additional FQHC covered services that are included in the all-inclusive PPS rate determination. As such, these services are not separately reimbursable.

Vaccines (including vaccine administration), drugs (identified by Health Care Financing Administration Common Procedural Coding System (HCPCS) with alphas such as A, C, J, S, and Q) and other medications (including those identified by National Drug Code (NDC numbers) as dispensed in a physician's office (i.e., physician-dispensed as opposed to FQHC owned pharmacy dispensed) by a FQHC provider on the date of FQHC covered professional visit are not separately reimbursable. The costs of the vaccines, drugs and other medications dispensed in the physician's office are allowable costs for FQHC PPS rate determination.

Other all-inclusive FQHC covered services may include intrauterine devices (IUD), diagnostic studies such as bone density, mammography, ultrasound of the pregnant uterus, contrast material used in radiology, etc., and foreign language and sign language interpreter services.

To the extent the cost of providing any of the above ancillary, diagnostic or medical devices or other medical services (other than those defined by the Medicare "Incident to" rule) has not been included in a FQHC's base PPS rate determination, the FQHC is eligible to apply for an adjusted PPS rate based on the Medicaid FQHC PPS Change in Scope methodology.

21.2.3 Services Not Eligible for PPS Reimbursement

Please refer to Appendix 1 of this manual for a list of services excluded from coverage under the Hawaii Medicaid State Plan.

Services covered under the State Plan but specifically excluded from FQHC PPS reimbursement (Non-FQHC PPS Services) include:

- Services provided by a physical therapist, occupational therapist, speech-language therapist and audiologist;
- Inpatient and outpatient hospital services provided by FQHC covered professionals at acute care hospitals, including vaginal or Cesarean delivery (Global billing for obstetrics services is not allowed); and
- Medications dispensed by a pharmacy that is part of the FQHC.

An FQHC may bill the Department or designated fiscal agent, including contracted health plan, for such Non-FQHC PPS Services provided by an employed or contracted practitioner. Non-FQHC PPS Services are not to be considered in calculations pertaining to PPS-based payments to FQHCs. In such instances, the Department, its designated fiscal agent, or the Medicaid managed care plan in which the patient is enrolled will reimburse the FQHC for Non-FQHC PPS Services on behalf of the practitioner at the rate specified for that practitioner under the State Plan or in accordance with the provider agreement with the health plan for the professional services provided to the Medicaid beneficiary.

FQHC “facility fees” are not covered. Like Medicare, Medicaid does not recognize free standing emergency rooms. Thus, no separate “facility fee” is payable if a Medicaid recipient is seen in a FQHC’s “emergency room.” The FQHC PPS rate includes both provider and facility costs. Thus, whether a FQHC outpatient visit is for emergency treatment or non-emergency treatment, the visit is an encounter and reimbursed at the PPS rate.

Telemedicine-based retinal imaging and interpretation is not a covered service for PPS reimbursement. It should be billed with the code and modifier 92014 SE and billed on the CMS 1500 form or electronically in CMS 1500 format. A face-to-face encounter with a member by an ophthalmologist or optometrist is eligible for PPS reimbursement, regardless of whether retinal imaging or interpretation is a component of the services provided.

Services Provided by Unlicensed Behavioral Health Providers under Supervision

- A face-to-face encounter with a licensed behavioral health provider is eligible for PPS reimbursement even if an unlicensed provider or other health care team member provides information to support the face-to-face encounter, provided that the licensed supervising provider was present for the key portions of the encounter and documents his or her treatment activities. Any support work provided by the unlicensed provider or other health care team member would then be considered included in the billing by the supervising provider and no separate claim should be submitted.

- In the absence of a face-to-face encounter by a licensed behavioral health professional, services provided by unlicensed behavioral health providers under supervision by licensed providers on the FQHC/RHC site are not eligible for PPS reimbursement. When the supervising provider is a Medicaid participating FQHC psychologist or psychiatrist, the FQHC/RHC can provide the MQD with a listing of its unlicensed behavioral health staff and a copy of their master's degree or higher (PsyD or PhD) and then submit claims for services supervised by the Medicaid participating FQHC psychologist or psychiatrist on the CMS 1500 form or in CMS 1500 format. The rendering provider is the supervising psychologist or psychiatrist. Reimbursement is made at 50% of Medicaid fee-for-service (FFS) rate. FQHC or RHC shall refer to ACS Memo M12-01 dated January 5, 2012 for further clarifications on qualifications, supervisory requirements and reimbursement.

21.2.4 Dental Services

Dental services are those provided by a Doctor of Dentistry. A separate dental encounter reimbursement rate covers the client's visit to the center, including all services and supplies incidental to that visit. Eligible services must meet the criteria in section 21.2.2.

FQHC/RHC school based dental services may be eligible for PPS reimbursement if they are:

- A covered service;
- Provided to an eligible recipient;
- Provided by a dentist licensed in Hawaii
- Provided through a Health Resources and Services Administration (HRSA) approved site including a mobile van.

21.3 REIMBURSEMENT

21.3.1 Reimbursement of Services

Covered services eligible for PPS reimbursement, as defined in Section 21.2, which are provided by Federally qualified health centers ("FQHC") and rural health clinics ("RHC"), shall be reimbursed on a prospective payment system ("PPS") that conforms to the requirements of section 702 of the Benefits Improvement and Protection Act of 2000 ("BIPA").

21.3.2 Definition of Change in Scope of Services

For purposes of this reimbursement methodology, a change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in cost alone will not be considered a change in scope of service.

An FQHC or RHC requesting a rate adjustment for changes in scope of service must submit data/documentation/schedules that substantiate any changes in services and the related adjustment of reasonable costs following Medicare principles of reimbursement.

Additionally, the net change in the FQHC's or RHC's per visit rates must equal or exceed 3 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish baseline PPS rates, the net change of 3 percent shall be applied to the average per visit rate of all the sites of the FQHC or RHC for purposes of calculating the costs associated with a scope of service change. "Net change" shall mean the per visit change attributable to the cumulative effect of all increases or decreases for a particular fiscal year. "Fiscal year" shall be construed to reference the fiscal year of the specific FQHC or RHC under consideration.

PPS rates may be adjusted for changes in the scope of services provided by an FQHC or RHC upon submission of a written notice to the Department specifying the changes in scope of service and the reasons for those changes within 60 days of the effective date of the changes. If the written notice is greater than 60 days after the effective date of changes the Department will consider the effective date of change of scope of services to be the notification date.

21.3.3 Payments by Managed Care Contracts

Effective January 1, 2015 for QUEST Integration (QI), if a FQHC/RHC provides services eligible for PPS reimbursement pursuant to a contract between the center and a QI Medicaid managed care entity, the managed care entity shall provide payment at the FQHC's PPS rate. If the FQHC has a new change in scope of service, the QI plan should continue to reimburse at the approved PPS rate until MQD revises its capitation payments to include the new rate. The MQD will adjust the FQHC's total payment based on the effective date of the new PPS rate through its reconciliation process, until

capitation payments to the QUEST Integration Medicaid Managed Care entity have been adjusted.

For FBDE/QMBPlus, where Medicare is the primary insurer, after payment by Medicare, QI plans shall pay FQHCs, which have a participating provider agreement with the QI plan, the difference between the Medicare payment and Medicaid PPS rate for FQHC PPS Services. For non-contracting FQHCs, the plan should pay Medicare co-payments and/or deductibles.

21.4 BILLING

21.4.1 Billing for Services

(A) Billing for FQHC PPS Services

The FQHC/RHC must bill for all services meeting the requirements of FQHC services using the National Provider Identification (NPI) Number established for that FQHC/RHC (not the individual practitioner's NPI # or Medicaid ID#). Additionally, the FQHC/RHC shall ensure that no staff or contract providers will seek separate reimbursement from the Department for services billed by the FQHC. The FQHC shall ensure that laboratory, radiological, and other services ordered by the FQHC staff, but provided by an organization independent of the FQHC be billed by the provider of the service and not the FQHC. The FQHC agrees to accept an all-inclusive payment amount for each primary medical care, behavioral health, or dental encounter based on the PPS rate established for that FQHC/RHC for services eligible for such reimbursement provided to eligible recipients.

Behavioral health individual therapy services provided by FQHC covered behavioral health professionals are billed in accordance with American Medical Association Current Procedural Terminology (CPT) including relevant time requirements.

(B) Billing for Non-FQHC PPS Services

In general, Non-FQHC PPS Services covered by Medicaid are reimbursed under the individual provider's NPI number on hard copy or electronic CMS 1500 claim forms. When Non-FQHC PPS Services are provided to FBDE and QMBPlus, the Department, its designated fiscal agent, or the Medicaid managed care plan in which the patient is enrolled will reimburse the FQHC only for applicable Medicare deductible and coinsurance.

21.4.1.1 Billing on the Same Day of Services at A Single Location

Federally Qualified Health Centers (FQHCs)/RHCs are paid a PPS all-inclusive rate for all services performed by the FQHC/RCH covered health care professionals (as defined in section 21.2.1) for each encounter with a Medicaid client per day. Contacts with one or more health care professionals and multiple contacts with the same health care professional that take place on the same day and at a single location shall constitute a single encounter unless:

i. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.
   a) Two (2) encounters are payable when the first encounter is for treatment of an acute and/or chronic condition such as cough/ fever and/or hypertension

and patient returns to the FQHC with an acute injury such laceration of the forearm, sprained ankle, etc. or

b) One (1) medical encounter is payable when the first encounter is for treatment of cough and fever and the second encounter is for a pelvic and breast exam for cancer screening.

c) One (1) medical encounter is payable when one (1) encounter is a face-to-face visit with a MD/DO and other encounter(s) is/are face-to-face visit(s) with an OD, DPM, or non-behavioral health APRN for the same, related, or unrelated condition(s).

ii. The patient makes visits for different types of services, specifically, dental or behavioral health. Medicaid shall pay for a maximum of one visit per day for each of these services in addition to one medical visit.

Medicaid pays for a maximum of three non-dental encounters per day, when the conditions in paragraphs (i) or (ii) above are met. This limitation does not include dental services. However, dental services are limited to one dental encounter per date of service.

If medical, behavioral health/psychiatry, and/or dental services are provided on the same day by the same FQHC/RHC, they must be submitted on different claim forms with diagnosis(es) clearly indicating the condition for which the service was provided. If the diagnosis(es) are the same for two or more revenue codes and/or two or more claims on the same date of service, only one claim line or revenue code will be paid. The FQHC PPS rates are based on one Medicaid covered encounter per day. Thus, additional services on the same day are allowed only when provided for unrelated medical reasons.

PPS eligible services not considered as behavioral health or dental are considered medical, and only one medical visit per day except as described above is covered regardless of the provider type. For example, although services by a Doctor of Podiatry or Doctor of Osteopathy (providing a medical service with or without osteopathic manipulation) qualify as a covered medical encounter, if these are performed on the same day as a visit to a physician's assistant, APRN, a Doctor of Medicine, or an optometrist, only one encounter is reimbursable.

21.4.2 Definition of a FQHC Encounter

FQHC encounters are face-to-face contacts between a patient and an FQHC covered professional for preventive and/or medically necessary services and include the FQHC facility costs, and all services, and supplies associated with the FQHC covered

professional's services. FQHC encounters also include services and/or supplies that are commonly furnished in a practitioner's office, without charge, included in the FQHC's facility costs, and/or furnished as incidental although an integral part of professional services.

Contacts with one or more health care professionals whether more than one is/are qualified (PPS reimbursable) or a combination of qualified and unqualified (not PPS reimbursable) and multiple contacts with the same qualified health care professional that take place on the same day and at a single location constitute a single encounter. Medicaid will only pay for one encounter per day, except as described in 21.4.1.1.

Billable FQHC encounters are face-to-face contacts between a patient and a FQHC covered professional. They include preventive services and medically necessary services such as lab services, diagnostic services such as EKGs, x-ray services (including ultrasounds), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable FQHC encounters for recipients in the fee-for-service Medicaid program are submitted to MQD for payment through its Fiscal Agent. Billable encounters for recipients in a QI plan are submitted to the plan in which the patient is enrolled.

Non-billable FQHC encounters are: (1) non-face-to-face contacts between a patient and FQHC covered health care professional; (2) face-to-face contacts between a patient and FQHC covered health care professional for non-FQHC covered services; and (3) face-to-face contacts between a patient and a FQHC non-covered professional such as a physical therapist, dental hygienist, and/or audiologist Health screening services in a clinic or community health fair setting such as weight check only or blood pressure check only are not eligible for FQHC PPS reimbursement.

A dental hygienist is not a covered FQHC health care professional. In order for his or her services to be billable, the dental hygienist must provide his or her services under the supervision of a licensed dentist who must have a face-to-face encounter with the patient on the same day. For example, the dentist sees the child and all the child needs that day is cleaning and fluoride application. Dentist can then have the dental hygienist do the service on that day. However, if the dentist tells the child to come back on another day and the dental hygienist does the cleaning without the dentist having a face to face with the patient, this encounter is not covered. Non-billable encounters should not be submitted to MQD or QI for FQHC PPS payment.

If the services are not covered by Medicaid, such as chiropractic services the FQHC can bill it as a non-covered service. However, if the service is covered but not covered for PPS reimbursement, the FQHC should bill as a professional service on the CMS 1500 Form.

21.4.3 Obstetric Services

Ultrasounds performed by a qualified PPS FQHC provider are included in the PPS covered prenatal visit. If medically necessary and within the FQHC covered professional's scope of practice, ultrasounds performed between prenatal visits are FQHC PPS eligible medical encounters if they include a face-to-face encounter with a FQHC covered professional.

Prenatal and post-partum care performed by FQHC covered professionals at the FQHC site are FQHC PPS covered medical encounters.

Maternity care and delivery using CPT-4 codes in the range 59XXX are not FQHC PPS covered medical encounters.

The delivery codes in the table below are payable to FQHC covered professionals but must be submitted in CMS 1500 format or hard copy to MQD's fiscal agent or the QI plan in which the woman is enrolled. The rendering provider is the FQHC covered professional (His/her NPI should be entered in Form Locator (FL) Block 24.J). The rendering provider or his/her designated agent must sign/electronically sign FL Block 31.

CODE	DESCRIPTION
59409	Vaginal delivery
59412	Turning of fetus from breech to presenting position
59414	Vaginal delivery of placenta
59514	Cesarean delivery
59525	Cesarean delivery with removal of uterus
59612	Vaginal delivery after prior cesarean delivery
59620	Cesarean delivery after vaginal delivery attempt due to prior cesarean delivery

The following CPT-4 obstetrical codes include prenatal and/or post-partum care. They are not payable when performed by the FQHC covered health care professional if the FQHC is providing prenatal and post-partum services at the FQHC site as FQHC PPS covered medical encounters.

59400, 59410, 59425, 59426, 59430, 59510, 59515, 59610, 59614, 59618, 59622

21.4.4 Surgery

Surgery performed by a FQHC covered health care professional in an outpatient setting during and after business hours on the FQHC's site is a FQHC PPS medical encounter.

Pre-operative and post-operative care by an FQHC covered health care professional at the FQHC site are FQHC PPS medical encounters whether or not the surgical procedure has designated follow-up days.

If surgery is performed by a FQHC covered health care professional at a site other than the FQHC, the surgical procedure itself must be submitted hardcopy on the CMS 1500 claim form or electronically in CMS 1500 format. The rendering provider is the FQHC covered Health care professional (Form Locator Block 24.J). The rendering provider or his/her designated agent must sign/electronically sign FL Block 31. The modifier -54 (surgical care only) should be appended to the CPT-4 surgical code when pre-operative and post-operative care have or will be done by a FQHC covered health care professional at the FQHC site.

21.4.5 Vision

Face-to-Face encounters by optometrists (ODs) and/or ophthalmologists (MDs or DOs) are FQHC PPS medical encounters. Such encounters include the provision of eyeware (e.g., frames, lenses, nose pads, and eyeglass cases), contact lenses for certain medical conditions, eye ware and contact lens fittings and repairs. Eyeware fittings/repairs and eyeware dispensing as the result of a face-to-face encounter are not separately reimbursable. For vision services covered by Medicaid, refer to ACS M07-17 dated September 28, 2007.

21.4.6 Claim Forms

When billing for Medicaid services in Hawaii, FQHC/RHCs must use either the UB-04 or dental claim forms or electronically in UB-04 format.

The FQHC/RHC must submit claims for all services provided by its professional staff using its FQHC/RHC provider number. Claims for FQHC covered professional services performed at the FQHC site are NOT payable on HCFA (CMS) 1500 forms or in 1500 format.

No more than one date of service can be submitted per UB-04 claim form per Medicaid client. Only one claim per day can be submitted for each allowable revenue code for a Medicaid covered service.

QI health plans may pay FQHCs on a UB-04 or CMS 1500 form. FQHC providers should check with health plans on the coding of claims.

21.4.7 Coding of Claims

• UB-04

a) Provider coding of revenue, diagnosis and procedures is required for all claims.

b) The Type of Bill on the UB-04 should always be 73X.

c) The revenue code used for billing is 0520 for medical or 0910 for behavioral health and 0529 for “other” non-covered encounters.

d) In addition to the revenue code, the FQHC must also include one of the specific CPT- 4 Code(s) designated for the revenue code(s) in the table below:

When Medicaid is the client’s primary health care insurer, the required revenue code and linked CPT(s) are as follows:

Revenue Code	**CPT Code**	**Usage (For illustration purposes only)**
0520	99212, G0101	All services performed on the FQHC/RHC site by FQHC/RHC professional staff including chronic care management, advance care planning and services by optometrists and vision supplies such as eye glasses (provided during a face to face encounter with a FQHC/RCH professional), podiatrists, doctors of osteopathic medicine.
0520	99212 or Medicare HCPCS code	For full-benefit dual eligibles only, services may be provided at the patient's place of residence, which may be a skilled nursing facility, a nursing facility or other institution used as a patient's home by any FQHC covered health care professional
0910	90804-90807, 90810-90811, 90847-90853, 90862;	Psychotherapy (individual and family therapy including the patient) in all outpatient settings, including medication management.

	Effective January 1, 2013, the following are FQHC covered behavioral health codes—90847 and individual psycho-therapy codes, 90832, 90834 and 90837, For psychiatrists and behavioral health APRNs/ psychologists with prescriptive authority, use 99212 with revenue code 0910 for medication management with/without psychotherapy less than 30 mins.	
0520	96150-96155	Health and behavioral assessments/interventions ONLY for FQHCs and RHCs with grants to provide integrated behavioral health services.
0529	99199	All services NOT covered by Medicaid. If a FQHC chooses to submit a claim for services non-covered by Medicaid, it MUST bill these services as non-covered charges. Failure to include these as non-covered charges will result in overpayments. It is each FQHC's responsibility to inform the State Fiscal Contractor of all

		overpayments. Recovery of all overpayments is a Medicaid requirement.

To expedite the processing of Medicare crossover claims, please use the codes that Medicare has instructed you to use for revenue codes 0520-0910

e) The coding system acceptable by the Division is the ICD-10-CM (International Classification of Diseases- Clinical Modification) for diagnosis(es), and the HCPCS (Health Care Administration Common Procedural Coding system) Level I (CPT) and Level II (HCPCS alpha numeric codes), the National Uniform Billing Committee's UB 04 revenue codes, and CDT (Current Dental Terminology) for dental procedures.

f) All outpatient dental services by FQHC/RHC dentists performed during and after FQHC business hours on the FQHC/RHC site should be submitted using codes D9999 (dental services for children/youth under 21 years of age), D0140 (with the ICD-10 diagnosis code K08.9. D0140 identifies adult emergency dental services). Claims for dental services must be filed using the American Dental Association (ADA) form 2006. Dental services performed in the inpatient acute care hospital, outpatient hospital, and ambulatory surgical center are billed as professional dental services on the ADA dental form and submitted to MQD's Dental Third Party Administrator (TPA). The rendering dentist's NPI# should be used in claim submittal. FQHC/RCH dental claims for all QI enrollees should be submitted to Hawaii Dental Services (HDS), Medicaid's Dental Third Party Administrator (TPA). Hospital, ambulatory surgical center facility services and anesthesiology and other physician services are billed to the QI plan.

21.4.8 Authorization

The following procedures address both the requirement that professional services performed by FQHCs and RHCs are claimed under the FQHC/RHC Medicaid provider number and that authorization requests comply with MQD rules.

The request for authorization of services on the DHS 1144 form must have the requesting physician's name (printed or typed), the physician's signature, and date in the appropriate blocks. At the time of the request for service, the physician must be a contracted provider with the FQHC/RHC.

In the "Provider Number" block, enter the FQHC provider number.

In the "Contact Name" block, enter "FQHC" or "RHC" and the name of the FQHC/RHC AND the contact name (if different from the physician).

In the “Telephone Number” and “Fax Number” blocks, enter the FQHC telephone/fax numbers at which that the requesting physician can be contacted if additional information is needed to process the DHS 1144 form.

It will be the responsibility of the FQHC or RHC to forward any and all Prior Authorization Correspondence Letters to the requesting physician.

21.4.9 Billing for Individuals who are Eligible for Medicare and Medicaid

When services are rendered to Medicaid clients who are also Full Benefit Dual Eligibles (FBDEs)/ Qualified Medicare Beneficiaries Pluses (QMBPlus), the FQHC must bill Medicare on the form as prescribed by the carrier processing the Medicare claim prior to submitting a claim for payment from Medicaid. More detailed information on billing Medicare can be found in Chapter 4 of this manual.

For Non-FQHC PPS Services, Qualified Medicare Beneficiaries ONLY (QMB Only as contrasted with QMBPlus) are only eligible for Medicaid payment of Medicare premiums, deductibles and coinsurance.

21.4.10 Billing for Individuals with other primary health insurance

For individuals not eligible for Medicare but who have other health insurances, The FQHC must bill the primary insurance first. Hawaii Medicaid and QI will pay the difference between the primary insurance payment and the FQHC’s PPS payment rate.

21.4.11 Appeals

A FQHC or RHC may appeal a decision made by the Department and shall be afforded an opportunity for administrative hearing under HRS Chapter 91. A FQHC or RHC aggrieved by the final decision and order of such an administrative hearing shall be entitled to judicial review in accordance with HRS Chapter 91, or may submit the matter to binding arbitration pursuant to HRS Chapter 658A.