PART II
RURAL HEALTH CLINICS
AND
FEDERALLY QUALIFIED HEALTH CENTERS
PROVIDER MANUAL

Introduction

<table>
<thead>
<tr>
<th>Section</th>
<th>BILLING INSTRUCTIONS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7000</td>
<td>CMS-1500 Billing Instructions</td>
<td>7-1</td>
</tr>
<tr>
<td></td>
<td>Submission of Claim Form</td>
<td>7-1</td>
</tr>
<tr>
<td>7010</td>
<td>Specific Billing Information</td>
<td>7-2</td>
</tr>
</tbody>
</table>

BENEFITS AND LIMITATIONS

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8100</td>
<td>Copayment</td>
<td>8-1</td>
</tr>
<tr>
<td>8300</td>
<td>Benefit Plans</td>
<td>8-2</td>
</tr>
<tr>
<td>8400</td>
<td>Medicaid</td>
<td>8-3</td>
</tr>
</tbody>
</table>

Forms Section
This is the provider specific section of the manual. This section of Part II was designed to provide information and instructions specific to RHC and FQHC providers. It is divided into four subsections: Billing Instructions, Benefits and Limitations, Appendices, and Forms.

**Billing Instructions** contains instructions on completion and submission of the HCFA-1500 CMS-1500 claim for paper billers.

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

The **Appendix** contains information concerning procedure codes. These appendices were developed to make finding and using procedure codes easier for the biller.

**HIPAA Compliance**

As a participant in the Kansas Medical Assistance program, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.
Introduction to the HCFA-1500 CMA-1500 Claim Form

RHC and FQHC providers must use the HCFA-1500 CMS-1500 claim form (unless submitting electronically) when requesting payment under the Kansas Medical Assistance Program. An example of the HCFA-1500 CMS-1500 claim form is in the Forms section at the end of this manual. The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

EDS does not furnish the HCFA-1500 CMS-1500 claim form to providers. Refer to Section 1100 of the General Introduction Provider Manual.

Complete, line by line instructions for completion of the HCFA-1500 CMS-1500 are available in the General Billing Provider Manual, pages 5-14 through 5-19.

SUBMISSION OF CLAIM:

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas  66601-3571

For information on KAN Be Healthy and billing for KAN Be Healthy screens, see the General Benefits Provider Manual, pages 2-6 through 2-14.
BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 11/03

Rural Health Clinic services require a copayment of $2.00 per encounter.

Federally Qualified Health Center (FQHC) services require a copayment of $3.00 per encounter.

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

Exceptions - Refer to section 3000 in the General TPL Manual for exceptions to copayment.

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

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

8200.
Reserved for future use.
BENEFITS AND LIMITATIONS

8300. Benefit Plan Updated 08/08

KMAP beneficiaries will be assigned to one or more Medical Assistance benefit plans. The assigned plan or plans will be listed on the beneficiary ID card. These benefit plans entitle the beneficiary to certain services. From the provider's perspective, these benefit plans are very similar to the type of coverage assignment in the previous MMIS. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the General Benefits Provider Manual for information on the plastic State of Kansas Medical Card and eligibility verification contact the Medical Assistance Customer Service Center at 1-800-933-6593 or (785) 274-5990.

For the MediKan benefit plan, psychotherapy is limited to a maximum of 24 hours per calendar year.
**RURAL HEALTH CLINICS (RHCs) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)**

Rural Health Clinic and Federally Qualified Health Center services are outpatient primary care services defined in 42 CFR Part 405, Subpart X. The Kansas Medicaid Program complies with scope, definitions, and criteria set forth in 42 CFR Part 405.2401 through 405.2472 and Publication 27, excluding portions that are specific to Medicare benefit and not applicable to Medicaid. Reimbursement for covered services furnished to eligible beneficiaries is in accordance with the provisions of the Benefits Improvement and Protection Act (BIPA) of 2000. RHCs are reimbursed for Medicare-covered RHC services, and FQHCs for Medicare-covered FQHC services plus covered Dental Services. Encounter rates are utilized for these payments. Other ambulatory services, if furnished by an RHC or FQHC, are reimbursed using the methodologies utilized in paying for same services in other settings.

**Enrollment**

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

Federally Qualified Health Centers (FQHCs) may enroll and bill for services with the Kansas Medical Assistance Program (KMAP) as separate and different provider types. Once FQHC providers initiate the enrollment process with KMAP’s fiscal agent for a different provider type, they will be contacted and requested to submit the additional information. The provider must submit documentation to SRS Medical Policy, to explain to SRS how the programs, personnel, accounting system, billing system, and facility square footage will be kept separate and independent for each provider type and how duplicate billing will be avoided.

Providers should send documentation to:

FQHC/RHC Fiscal Manager  
Health Care Policy Medical Policy  
Kansas Department of Social and Rehabilitation Services  
Docking State Office Building, 6th Floor South  
Topeka, Ks  66612

**Visit or Encounter**

A covered rural health clinic or federally qualified health center “visit” means a face-to-face encounter between a clinic/center patient and a clinic/center health care professional or practitioner (listed below) during which a covered RHC/FQHC service or dental service is rendered:
8400. Updated 3/05

- Physician,
- Physician Assistant (PA),
- Advanced Registered Nurse Practitioner (ARNP),
- Nurse Midwife,
- Dentist (for FQHCs only),
- Clinical Psychologist,
- Clinical Social Worker,
- Registered Nurse for KAN-Be-Healthy nursing screen only, bill with the modifier “TD”.
- Visiting Nurse (if the conditions listed under “visiting nurse services” are fulfilled)

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

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

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

**Health Care Professional or Practitioner Requirements**

The practitioner should either be an employee or an owner of the RHC/FQHC. A qualified practitioner under contractual arrangement to receive compensation from the RHC/FQHC also qualifies. The RN that performs KBH nursing assessments must be an employee of the RHC/FQHC.

**More Than One Encounter on the Same Day**

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

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

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

- different procedure codes, use modifier “25”
- same procedure code, use modifier “76” first, followed by modifier “25”.
Place-of-Service Criteria

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

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

If the RHC or FQHC services are in a setting outside of the clinic, the appropriate POS code must be used. For example, if a RHC or FQHC service is provided in a skilled nursing facility (SNF), POS code 31 is applicable. If an RHC or FQHC service is provided in the home, POS code 12 is applicable.

POS code 99 (other) must be used for dental services FQHCs providing dental services must use POS “Other” for dental services provided in the FQHC. POS code 50 is not currently an option on the American Dental Association standard paper form. Dental claims should not be billed using POS code 11, since this code was discontinued for dates of service on and after May 1, 2008. This applies to paper claims only. For all other claims, providers will continue to use POS 50.

Services that are considered non-RHC and non-FQHC, such as the technical components of radiology, electrocardiogram (EKG), and clinical diagnostic lab services, must be billed as they are currently being billed (using POS code 11).

Services Away from the Clinic or Center
If the services are furnished at a location other than the facility (e.g., the patient’s place of residence, the scene of an accident), their coverage as RHC/FQHC encounters depends on whether there is an agreement that the clinic/center would compensate the practitioner for furnishing services in a location away from the clinic/center. The following criteria apply for billing for these services:

- Practitioner Compensated: The services are covered as RHC/FQHC visits and should only be billed under the RHC/FQHC provider number. It may not be billed under any other Medicaid provider number.
- Practitioner Not Compensated: The services are not covered as RHC/FQHC visits. It can be billed under a different (e.g., a professional) Medicaid provider number.

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

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

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

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

- Professional services furnished by clinic/center practitioners
- Services and supplies “incident to” a practitioner’s services

Examples of covered services:

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

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

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

Content of Service

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

- “Incident to” services and supplies. Those services of the clinic/center health care staff (such as a nurse or a therapist) and supplies (such as tongue depressor, bandage, thermometer) that must be an integral, although incidental, part of the rendition of a practitioner’s personal professional services in the course of diagnosis or treatment of an injury or illness. To be covered as “incident to,” a service or supply must be:
  - Furnished by a member of the clinic/center’s health care staff who is an employee of the clinic or center.
  - Rendered under direct, personal, medical (not administrative) supervision of a physician.
  - Of a type commonly furnished in a physician’s office without separate charge, performed away from the clinic/center facility only when accompanying a practitioner.
8400. Updated 3/06

- Professional component of Radiology and EKG if performed by a clinic/center practitioner.
- Drugs and biologicals that are not usually self-administered.
- Administration of vaccine, immunization, or other injection

Limitations and Requirements

Limitations that currently apply to covered services under the state plan, also apply when provided by RHCs/FQHCs.

Other insurance is primary and must be billed first. Refer to Section 3100.

Lock-in referrals are required for consumers locked into Medicaid providers.

RHC services require (unless otherwise specified) a referral from the consumer’s primary care case manager (PCCM).

Co-payment is applicable.

Non-Covered Services

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

Services furnished by auxiliary health care staff who are not employed by the clinic or center.

Services provided by auxiliary health care employees at the facility without direct supervision of a clinic or center practitioner.

Services furnished by auxiliary health care employees away from the clinic/center facility when the employee goes to the site alone, without a clinic/center practitioner.

Technical components of Radiology and EKG.
Clinical diagnostic laboratory services including the six required lab tests for RHC certification.

Health care services performed by outside entities, including those owned by the center’s owner(s) or staff. The State Plan requires that providers of these services bill Medicaid directly.

Drugs and biologicals which can be self-administered. For example, oral prescription drugs, insulin injections.

**Dental Services (FQHCs only)**

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

**Family Planning**

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

**Transcervical Sterilizations:**

Procedure code 58579 is not covered for transcervical sterilization procedures. Procedure code 58565 is to be used. The procedure must meet all sterilization requirements. Prior authorization is required.

The Essure Kit is included in procedure code 58565 and should not be billed separately. The invoice does not need to be attached to the claim.

Procedure code 58340 (SIS/HSG test) is covered as part of the transcervical sterilization process. This code will be paid only if the transcervical sterilization has been paid previously and the sterilization was performed more than three months prior to the date of service. If a beneficiary has had a transcervical hysteroscopy sterilization, a federal sterilization consent form is required. Additionally, three months must have passed before having the catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography (HSG) – procedure code 58340. To indicate proof of sterilization, ICD-9 CM diagnosis code V25.2 must be used. Prior authorization is not required.
Mental Health Services

**Admission Evaluation (Diagnostic)**

- The gathering of initial diagnostic information including social history to plan appropriate treatment.
- The admission evaluation may include communication with family or other sources.
- Five hours of evaluation are allowed per calendar year per consumer.

**Case Conference**

- Case conference is a scheduled face-to-face meeting between two or more individuals to discuss problems associated with the consumers’s treatment.
- The conference may include treatment staff, collateral contact or consumers, and other agency representatives, not including court appearances and/or testimony.
- Six hours of case conferences are allowed per calendar year for consumers not participating in the KAN Be Healthy Program. KAN Be Healthy participants are allowed twelve hours per calendar year.

**Family Therapy**

- Therapy that involves the treatment of the family as a “system” with the family being the focus, specifically including children (may refer to adult children). Therapy must be conducted under a treatment plan approved by the physician.
- Family therapy, or a combination of family and group therapy, is limited to 40 hours per calendar year, per consumer.
- Family and Group therapy in any combination are limited to 24 hours per calendar year for MediKan consumers.

**Group Therapy**

- Therapy delivered in a group setting to two or more unrelated individuals. Service must be conducted under a treatment plan approved by the physician.
- Group therapy, or a combination of group and family therapy, is limited to 40 hours per calendar year, per consumer.

Group and family therapy in any combination are limited to 24 hours per calendar year for MediKan consumers.
Individual Therapy

- This is one-to-one therapy provided under a treatment plan approved by the psychiatrist or physician skilled in the treatment of mental disorders.
- Individual therapy is limited to 32 hours per calendar year for consumers not participating in the KAN Be Healthy Program. Forty (40) hours per calendar year are allowed for KAN Be Healthy participants.
- Individual therapy is limited to 24 hours per calendar year for MediKan consumers.
- Individual and group therapy or family therapy are covered when there is a treatment plan containing a psychiatric diagnosis and goals of treatment. This limitation will be monitored post pay and will require the provider to document, in legible writing, the amount of time spent in therapy, major issues covered and changes in medication, diagnosis, condition, treatment plan or course of treatment. The provider must document that a review of the treatment plan has been conducted every three months.

Newborn Home Visit

Newborn visit in a consumer’s home must be provided by a clinic/center practitioner. It is limited to one visit per newborn, 1 to 28 days after birth. A home visit by auxiliary staff without a practitioner is non-covered.

A newborn home visit consists of the following:

- Maternal Assessment
- Newborn Assessment
- Parenting and Home Assessment
- Education

A primary care case management referral is not required to provide this service.

Obstetrical Services

No “bundled” codes are allowed for RHC/FQHC billing under the Kansas Medicaid Program. Traditionally “bundled” obstetrical services, such as routine obstetrical care, should be “unbundled” and billed separately on per encounter basis. Prenatal visits and postnatal visits can be billed by the clinic/center using the appropriate CPT codes, whereas other unbundled components of “bundled” services should not be billed under the RHC/FQHC provider number unless the services are furnished in an “approved” setting (see Place-of-Service Criteria). When furnished in a non-approved setting, such as a hospital, these services can be billed under the practitioner’s provider number using separate CPT codes for unbundled services (e.g., 59409 for vaginal delivery, 59514 for caesarian delivery). Global codes (e.g., 59400, 59510) should not be used when unbundled portions of traditionally bundled services are billed under more than one Medicaid provider.

OB Global billing claims with a TPL paid amount.

Effective with service dates on and after January 1, 2003, RHC/FQHC’s billing global OB codes with TPL require a manual process for payment. These claims are to be sent to the Provider Relations Unit of the Fiscal Agent with the following documentation:
8400. Updated 11/03

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

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

Send the claims to:
EDS - Provider Rep Unit
Attn. Provider Rep Business Analyst
3600 SW Topeka Blvd., Suite 204
Topeka, Ks 66611.

**Visiting Nurse Services**

Part time or intermittent nursing care provided in a patient’s place of residence may be billed as an encounter if:
- the clinic/center is located in an area designated as an area with a shortage of home health agencies;
- the services are rendered to a homebound patient who is confined to his/her place of residence;
- the “place of residence” is NOT a hospital, long term facility, or skilled nursing facility (SNF);
- the services are furnished by an RN or LPN who is employed by or receives compensation from the RHC/FQHC;
- the services are furnished under a written plan of treatment reviewed at least every 60 days; and
- the services consist of nursing care performed by an RN or LPN. This does not include housekeeping services.

**Commingling**

Commingling is the blending of an RHC’s or FQHC’s operations with another entity or entities, such as a physician’s practice, lab, etc., with commensurate sharing of space, staff, supplies, and other resources. They may or may not be located in the same building. A defined physical area, hours of operation, each practitioner’s and staff’s time, and other resources devoted only to RHC or FQHC operation should be set aside in advance and distinguished from other entities. This separation must be maintained at all times while performing day-to-day functions and reflected in all RHC/FQHC records, bills submitted for services rendered, and cost reports. Examples of the separation of RHC/FQHC operations from other related entities include:
• RHC/FQHC practitioners and auxiliary staff (both medical and administrative/overhead) should not simultaneously provide services to the RHC/FQHC and other entities. Different staff, or different hours of the same (common) staff, must be scheduled for conducting clinic/center business and that of other entities.
• During the time a practitioner is scheduled to work for other entities (e.g., a private practice), his/her services must NOT be billed under the RHC/FQHC provider number. During the time a practitioner is scheduled to work for the RHC/FQHC and his/her time is being charged to the clinic/center, he/she should not treat patients that are not clinic/center patients. The services rendered to clinic/center patients during this time should only be billed under the RHC/FQHC provider number.
• If an RHC/FQHC and other entities share supplies, equipment, or other resources; the cost attributable to each entity must be determined using a logical basis (e.g., square footage for building related costs, charge sheets with actual usage for medical supply cost, etc.) and distinguished in the facility records. At the time of cost reporting, either just the clinic/center’s portion should be reported on the RHC/FQHC cost report, or if the entire cost of the shared resource is included on the RHC/FQHC cost report, the portion attributable to other entities should be carved out.
• 42 CFR 491.10 requires RHCs and FQHCs to maintain records for each patient which include specific personal and medical information. RHC/FQHC patient records must be separate from other entities’ patient records.

Reimbursement

Effective January 1, 2001, the Kansas Medicaid Program has established the Prospective Payment System (PPS) for RHCs and FQHCs mandated by the Benefits Improvement and Protection Act (BIPA) of 2000. As an alternative to PPS, providers have the option to receive reimbursement under the Modified Cost-Based System (CBS) by submitting a written request. If the state does not receive a RHC’s or FQHC’s request at least 45 days prior to the beginning of the facility fiscal year, that provider will automatically be reimbursed under the PPS for the entire fiscal year. Once CBS is elected by a facility, that method will remain in effect until directed by the facility by written request to change methods. A facility may choose to change methods on an annual basis by written request.

Criteria for Electing Modified CBS
For facility fiscal years beginning on and after October 1, 2001, the written request should be received in our office no later than forty five (45) days prior to the beginning of the reporting year.
Prospective Payment System (PPS)
Under this methodology, clinics/centers are paid prospective rates based on an average of the reasonable costs for the two base years with no retroactive cost settlements.

Modified CBS
Under this payment system, interim payments are reconciled to the greater of cost-based or PPS-based amount by utilizing fiscal year-end retroactive settlements.

Change in Scope of Services
If a RHC or FQHC expects a change in the scope of covered services, a written description of the proposed change with budgeted increase or decrease in cost and total number of visits should be submitted to the state. An adjustment to the rate may be made based on a review of the submitted information.

Medicaid Paid Claims Summaries
Providers may request these by calling SRS Medical Policy at (785) 296-3981.

Rate Setting

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

Initial Rate for Newly Enrolled Providers

Provider Already Established As RHC or FQHC Before Medicaid Enrollment - PPS baseline rate will be derived from finalized Medicare cost reports covering the two most recent fiscal years.

Newly Certified RHC/FQHC - The average of the rates paid to other similar RHC/FQHCs in the area will be used.

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

For providers enrolled before January 1, 2001, the base years are facility fiscal years 1999 and 2000.

For new providers that are already established RHCs or FQHCs at the time of enrollment, base years are the two most recent facility fiscal years.

For clinics or centers newly certified as RHCs or FQHCs, base years are the two fiscal years following the first year in business as an RHC or FQHC.

PPS Rate Determination
PPS rate is an average of the rates from the two base years. Each base year’s rate for an RHC is the Medicare rate obtained from the finalized Medicare cost report. Each base year’s rate for an FQHC is computed by Medicaid from reasonable costs and adjusted total visits derived from the cost report.
8400. Updated 11/03

**PPS Baseline Rate**
Baseline rate is the PPS rate derived from an RHC’s or FQHC’s base years:
- **Providers Enrolled Before January 1, 2001:** It will be effective 1/1/2001 to 9/30/2001.
- **New Providers:** It will be effective from the enrollment date through the following September 30.

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

**Cost Reports**

RHCs are not required to submit cost reports to Medicaid. The Department uses finalized Medicare cost reports. For freestanding RHCs, RHC cost reports received from the Medicare intermediary for independent RHCs are used. For provider-based RHCs, hospital cost reports received from the Medicare intermediary for hospitals are used.

Each FQHC is required to submit the same cost report as the one filed with Medicare on the most recent version of Form HCFA-222-92 (Rev. July 1994) within five (5) months after the fiscal year end. The only differences between Medicare and Medicaid cost reports are Dentist visits and KBH Nursing Assessments which are not recognized by Medicare. A productivity standard of 2,100 should be used for reporting Dentist visits. The cost report should be supplemented by the information listed below and all other supporting documents must be available for review:
- a detailed trial balance which includes cost report line numbers for cross-checking,
- independent auditor’s report and management letter,
- an itemized list of revenue including source and purpose,
- any additional information necessary to facilitate reconciliation of reported expenditures with the trial balance and financial statements.

**Managed Care Entity (MCE) Contracts**

If an RHC or FQHC provides covered services to eligible Medicaid beneficiaries under a contract with a Medicaid managed care entity (MCE), the provider is entitled to a settlement from Medicaid consisting of the difference between MCE payments and the amount Medicaid would have paid under the payment methodology elected by the provider for that fiscal year. Depending on the elected reimbursement methodology, the settlement will be in one or two stages:
Quarterly Supplemental Payments: All providers must send copies of the remittance advices received from the MCE after the end of each quarter. Regardless of the payment methodology, the State will compute “quarterly alternative amounts” by applying the provider’s Medicaid PPS or interim rate to covered encounters paid by the MCE. If it is higher than MCE payments, Medicaid will pay the difference to the provider. If it is lower, the provider will refund the overpayment to the agency.

Fiscal Year-End Settlement: This applies only if the alternative option, modified CBS, has been elected by the provider for Medicaid reimbursement. At the time of final retroactive cost settlement for Medicaid payments, the State will also make a final settlement on services provided under the MCE contract. A “yearly alternative amount” will be computed and compared with total MCE payment plus or minus the quarterly supplemental payments. If the yearly alternative amount is higher, Medicaid will pay the difference to the provider. If it is lower, the provider will refund the overpayment to the agency.

Other Ambulatory Services

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