MSA Medical Services Administration Bulletin

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Programs Affected: Medicaid

The attached Medicaid Provider Manual pages revise and update policy and procedures for Federally Qualified Health Centers (FQHCs). These updates incorporate and implement changes required by federal law pursuant to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. BIPA introduced a prospective payment system (PPS) for services provided by FQHCs on and after January 1, 2001, and this policy reflects corresponding policy and reimbursement changes.

Chapter Formatting

The attached manual chapter was formatted to facilitate its incorporation into a single all-provider electronic manual, and references are made to other chapters that may not be part of your current provider-specific manual. Until the all-provider manual is issued on CD in early 2004, providers may access these chapters (e.g. Practitioner, Billing and Reimbursement, etc.), on the MDCH website at www.michigan.gov/mdch. Click on Providers, click on Information for Medicaid Providers, click on Medicaid Policy. Providers may also access forms on the website.

Manual Maintenance

Discard Chapters I, II, III, IV and V of the FQHC Manual and replace with the attached chapter. Retain Tribal Health Centers Appendix. This bulletin may be discarded once the manual maintenance is completed.

Questions

Any questions regarding this bulletin should be directed to: Provider Support, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free: 1-800-292-2550.

Approved

Paul Reinhart, Director
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FEDERALLY QUALIFIED HEALTH CENTERS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Federally Qualified Health Centers (FQHCs) and Tribal Health Centers (THCs). All subsequent references to FQHCs are intended to apply also to THCs as designated by the Centers of Medicare and Medicaid Services (CMS). This chapter provides policy and reimbursement information specific to FQHCs and is to be used in combination with other chapters in this Medicaid Provider Manual.

Section 330 of the Public Health Service Act establishes guidelines for health centers applying for grant funding under the Health Centers Consolidation Act of 1996 (Public Law 104-299). This act combined four federal health center grant programs under one authority (community, migrant, homeless and public housing). Health centers applying for and meeting the criteria for grant funding under Section 330 are eligible to be recognized as FQHCs by CMS for reimbursement purposes. Once FQHC status is designated by CMS and notification of that status is provided to the Michigan Department of Community Health (MDCH), an FQHC is eligible to enroll with Medicaid as an FQHC provider in the State of Michigan.

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 makes provision for the reimbursement of FQHCs under a prospective payment system (PPS). This PPS applies to the ambulatory/outpatient medical services that FQHCs are required under federal regulation to provide to Medicaid beneficiaries.

Under BIPA, states may elect to reimburse FQHCs under the PPS methodology outlined in the law or they may choose to implement an alternative payment methodology that is agreed to by the FQHC and the state. If an alternative methodology is implemented, it must result in payment at least equal to that which an FQHC would receive under the BIPA PPS.

1.1 MEMORANDUM OF AGREEMENT FOR REIMBURSEMENT

MDCH may enter into an alternative reimbursement methodology with the FQHC known as a Memorandum of Agreement (MOA). Reimbursement for Medicaid primary care services provided by an FQHC to Medicaid beneficiaries is subject to the terms of the signed MOA. The MOA provides reimbursement at least equal to that which the FQHC would have received under the PPS required under federal regulation (BIPA 2000).

The MOA is effective when both MDCH and an FQHC are signatories to the document. The signed agreement supersedes any corresponding policy in the Medicaid Provider Manual. If an FQHC does not sign the MOA, reimbursement and corresponding policy deafults to that which is outlined in this policy manual.

1.2 ENROLLMENT

Each FQHC that is certified by CMS to provide services as a Medicare-enrolled FQHC is eligible to apply to MDCH to be a Medicaid provider. To apply, the FQHC must submit the CMS Medicare certification letter to the MDCH Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.) The FQHC must also notify the MDCH Hospital and Health Plan Reimbursement Division (HHPRD) of certification and enrollment in order to be reimbursed under the PPS.

Each FQHC employed physician (MD, DO), dentist, optometrist, certified nurse practitioner (CNP), and certified nurse midwife (CNM) must be enrolled as a Medicaid provider. Any of these practitioners who is subcontracted with an FQHC must be enrolled as the FQHC's employee in order to be reimbursed under

the FQHC PPS. (Refer to the General Information for Providers Chapter of this manual for enrollment information.)

The FQHC has responsibility for notifying the Provider Enrollment Unit and HHPRD of any new physicians, dentists, optometrists, CNPs, CNMs, and/or subcontractors joining the FQHC. To notify MDCH, attach a copy of the original CMS FQHC certification letter to the Medical Assistance Provider Enrollment Agreement (DCH-1625). These documents are required to approve the practitioner as a provider of FQHC services. (Refer to the Directory Appendix for contact information.)

The FQHC must provide MDCH Provider Enrollment Unit and HHPRD with written notification of any terminating physicians, dentists, optometrists, CNPs, CNMs, and/or subcontractors leaving the FQHC. In the letter, the provider's name, Medicaid identification (ID) number, and termination date must be identified.

FQHC services that are furnished under contract with physicians, clinical social workers, clinical psychologists, physician assistants, certified family and pediatric NPs, visiting nurses, and other approved professionals are billed as FQHC services. However, preventive primary services must be provided by an employee of the FQHC or by a physician under contract with the FQHC. Preventive primary services do not qualify as FQHC services if non-employee providers (except physicians) contracting with the FQHC provide the services.

1.3 Site Specific Certification

FQHCs are required to submit to the MDCH Provider Enrollment Unit documentation of CMS approval as an FQHC provider for each site operated by the FQHC prior to Medicaid enrollment of that site. Satellite FQHC sites not approved by CMS are not eligible for FQHC PPS reimbursement. Copies of approval letters from CMS must be sent to the MDCH HHPRD. (Refer to Directory Appendix for contact information.)

1.4 Allowable Places Of Service

Services provided to beneficiaries within the four walls of the FQHC and approved FQHC satellites are allowable for reimbursement under the PPS.

Off-site services provided by employed practitioners of the FQHC to patients temporarily homebound or in any skilled nursing facility because of a medical condition that prevents the patient from going to the FQHC for health care are also allowable for reimbursement under the PPS.

1.5 Non-Enrolled Provider services

Professional services provided by FQHC clinical social workers, clinical psychologists, and physician's assistants are reimbursed under the PPS. However, these providers are not enrolled in Medicaid and, accordingly, do not have their own Medicaid provider identification (ID) numbers. Services provided by these professionals must be billed under the supervising physician's Medicaid ID number. The supervising physician is responsible for ensuring the medical necessity and appropriateness of these services. The clinical psychologist and clinical social worker services must be billed with the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Manual.

All FQHCs may bill the clinical social worker and clinical psychologist services but are limited to 20 visits per beneficiary per calendar year. Visits beyond the maximum of 20 visits per beneficiary per calendar year will be rejected. Services provided to enrollees of a Medicaid Health Plan (MHP) must be prior authorized by the health plan.

SECTION 2 – BENEFITS

FQHC services subject to PPS reimbursement are FQHC services defined at Section 1861 (aa)(1)(A)-(C) of the Social Security Act.

2.1 PRIMARY CARE SERVICES

Primary care services are defined as:

- Those required under Section 330 of the Public Health Service Act.
- Medicaid-covered services provided in a place of service that is the FQHC's office or clinic, patient's home, Domiciliary Facility Nursing Home, Nursing Facility (NF), or Skilled Nursing Facility by a provider type physician, medical clinic, podiatrist, dentist, CNP or CNM.
- Medicaid-covered inpatient hospital care (as specified in the MOA) limited to the following procedures:
  - Initial inpatient consultations
  - Follow-up inpatient consultations
  - Initial hospital care
  - Subsequent hospital care, and
  - Newborn care
- Visits by a clinical psychologist or clinical social worker at the FQHC's office or clinic, patient's home, Domiciliary Facility Nursing Home, Nursing Facility, or Skilled Nursing Facility
- Other ambulatory services, i.e., Medicaid transportation, Medicaid outreach, and Maternal Support Services (MSS) and Infant Support Services (ISS).

2.2 TRANSPORTATION

Non-emergency transportation of the Medicaid beneficiary to and from the FQHC is covered. MDCH requires Medicaid transportation documentation. This documentation would include actual mileage per trip, total mileage for fiscal year, beneficiary Medicaid ID Number and date of service (DOS). The documentation may be requested by HHPRD after the annual reconciliation report has been filed.

SECTION 3 – ENCOUNTERS

3.1 DEFINITION

An allowable FQHC encounter means a face-to-face medical visit between a patient and the provider of health care services who exercises independent judgment in the provision of health care services.

An encounter occurs between a medical provider and a patient when medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of an illness or injury. Included in this category are physician visits and mid-level practitioner visits. Family planning medical visits are a subset of medical visits.

An encounter occurs between a dentist or dental hygienist and a patient when services are for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. A dental hygienist is credited with an encounter only when the professional provides a service independently, not jointly with a dentist. However, two encounters may not be billed for the dental clinic in one day.

An encounter occurs between a speech or physical therapist, audiologist, occupational therapist, clinical psychologist, or clinical social worker and a patient when allied health or mental health services are provided. Allied health services are those provided by specially trained health workers, other than medical and dental personnel. Mental health services are those of a psychological or crisis intervention nature or related to alcohol or drug abuse treatment. For the purpose of these reports, visits with a psychiatrist are included under medical visits.

The following examples help to define an encounter:

- To meet the encounter criteria for independent judgment, the provider must be acting independently and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate encounter.
- Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling/dispensing prescriptions, or optician services, in and of themselves, do not constitute encounters. However, these procedures may accompany services performed by medical, dental, or other health providers that do constitute encounters.
- Encounters must be documented in the medical record. When a provider renders services to several patients simultaneously, the provider can be credited with a visit for each person if the provision of services is noted in each person's health record. This also applies to family therapy or counseling sessions in which several members of the family receive services relating to mutual family problems and the services are noted in each family member's health record.
- The same billing limitations identified in the General Information Chapter of this manual apply to claims submitted for FQHC encounters.

The encounter criteria are **not** met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide health services.

- When the only service provided is part of a larger scale effort, such as a mass immunization program, screening program, or community-wide service program.
- When the following services are provided as stand-alone services: taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling/dispensing prescriptions. Refilling prescriptions, filling out insurance forms, etc., are not visits. Allergy injection(s) are not visits.

3.2 Medicaid Health Plans or Children's Special Health Care Services Special Health Plans

Medicaid-covered services provided by an FQHC to Medicaid-eligible beneficiaries enrolled with an MHP or Children's Special Health Care Services (CSHCS) Special Health Plan (SHP) are subject to the PPS when the following conditions are met:

- The FQHC and the MHP or SHP must be signatories to a contract that addresses the FQHC providing Medicaid covered services to an MHP or SHP enrollee.
- The contract must provide for the MHP or SHP to reimburse the FQHC at a fair market rate for similarly situated beneficiaries served by a non-PPS provider. The contractor must implement a payment method equal to, or above that of, other affiliated inter-plan and intra-plan subcontracting arrangements when entering into a subcontract with an FQHC.
- The FQHC must request that MDCH pay the PPS rate for MHP or SHP enrollees.

MHP or SHP beneficiaries are identified with a Level of Care Code 07. Providers must verify eligibility through the eligibility verification system (EVS) before providing services. (Refer to the Eligibility Chapter of this manual for additional information.)

3.3 Healthy Kids Dental

Dental services provided to Medicaid beneficiaries enrolled in the Healthy Kids Dental program are subject to the PPS or MOA rate.

3.4 Substance Abuse Coordinating Agency

Services provided by a Substance Abuse Coordinating Agency (CA) are subject to the PPS or MOA rate when contracted between the FQHC and the CA.

3.5 Allowable Encounters Per Day

An individual provider may be credited with no more than one encounter per patient during a single day, except when the patient, after the first visit, suffers illness or injury requiring additional diagnosis or treatment. For example, a patient sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be classified as two encounters.

An FQHC is entitled to two encounters for different types of visits on the same day. For example, a patient first sees a physician at the FQHC and then later sees a dentist. These visits may be classified as two encounters.

3.6 SERVICES AND SUPPLIES INCIDENTAL TO AN FQHC ENCOUNTER

Services and supplies incident to a FQHC encounter are included in the PPS reimbursement if the service or supply is:

- Of a type commonly furnished in physicians' offices.
- Of a type commonly rendered either without charge or included in the professional bill.
- Furnished as an incidental, although integral part of professional services furnished by a physician, CNP, CNM, or physician's assistant.
- Furnished under the direct personal supervision of a physician, CNP, CNM, or physician's assistant.
- In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a CNP, CNM, or physician's assistant only if such a person is permitted to supervise such services under the written policies governing the FQHC.

SECTION 4 – BILLING

FQHC services must be billed according to instructions published in the Billing and Reimbursement for Professionals Chapter of this manual. FQHCs must refer to this chapter for information needed to submit professional claims for Medicaid services, as well as information about how MDCH processes claims and notifies the FQHC of its action. Policies for specific services are found in the provider-specific chapters of this manual.

It is the responsibility of the FQHC to properly bill all Medicaid FFS claims. Since the annual reconciliation and final reimbursement is based on approved Medicaid claims, incorrect or improper billing may adversely effect reimbursement.

MDCH strongly encourages electronic submission of claims.

The FQHC's MDCH-approved claims must be available for review by authorized personnel or agents of MDCH, the Health Care Fraud Division of the Michigan Department of Attorney General, and U S Department of HHS in conformity with the provisions of the Social Security Act.

4.1 PLACE OF SERVICE

When billing services provided within the FQHC, the appropriate place of service code is 50. For services not provided in the FQHC, bill the appropriate place of service code listed in the Billing & Reimbursement for Professionals Chapter of this manual.

FQHCs providing Medicaid-covered services in locations other than the FQHC office, home, nursing facility or domiciliary facility are reimbursed at Medicaid fee screens.

4.2 COORDINATION OF BENEFITS

It is the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to the provision of a service. Providers must bill third party payers and receive payment to the fullest extent possible before billing Medicaid. Private health care coverage and accident insurance, including coverage held by, or on behalf of, a Medicaid beneficiary is considered primary and must be billed according to the rules of the specific commercial plan. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

The MDCH is not liable for payment of services that would have been covered by the private payer if applicable rules of that private plan had been followed. The beneficiary must seek care from network providers and authorizations or referrals must be obtained as required. If the provider does not participate with the commercial carrier, the provider is expected to refer the beneficiary to a participating provider.

Some private commercial managed care plans involve a capitation rate and fixed co-pay amount. In this instance, it is impossible to determine a specific other insurance payment. MDCH will pay a fixed co-pay amount up to our maximum allowable fee for the service.

4.2.A. Other Insurance and Coverage Payments

All other insurance payments received for services rendered to a Medicaid beneficiary must be reported on the claim submitted to Medicaid. Even if the other insurance payment for a specific service exceeds the amount Medicaid would have paid, the FQHC must still bill the FFS procedure code to receive credit for the encounter. (Refer to the Billing and Reimbursement for Professionals Chapter of this manual for specific billing guidelines.)

4.2.B. Medicare and Medicaid Crossover Claims

If a Medicaid beneficiary has Medicare and Medicaid, the FQHC must follow the billing instructions in the Billing and Reimbursement for Professionals Chapter of this manual. Even if the Medicare payment exceeds the Medicaid fee screen, the FQHC must still bill the FFS procedure code to receive credit for the encounter.

4.3 Co-Payments

The Medicaid co-payments for chiropractic, dental, podiatry, and vision services are waived under the FQHC benefit as part of the reconciliation. (Services requiring co-payment are listed in the General Information for Providers Chapter of this manual.)

4.4 Dental Claim Submission

FQHCs submitting paper claims must submit the American Dental Association (ADA) Version 2000 claim form for Medicaid reimbursement. FQHCs must refer to the Dental Chapter in this manual for information regarding prior authorization (PA) instructions and claims completion.

Dentists may purchase the ADA Version 2000 paper claim form directly from the American Dental Association or through ADA-approved vendors. The ADA claim forms are not supplied by the MDCH.

4.5 Billing for Maternity Care

Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of services (FQHC and hospital). In order for the FQHC to be reimbursed for prenatal visits under the PPS methodology, the FQHC should not bill for global maternity care. The claims for delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care should be billed with a FQHC place of service (50) using the appropriate prenatal codes. These prenatal services will be reimbursed under the PPS methodology.

If the FQHC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.

SECTION 5 – MEDICAID RECONCILIATION REPORT

5.1 RECONCILIATION OF FEE-FOR-SERVICE

Each FQHC is required to submit an annual Medicaid Reconciliation Report. MDCH will include as part of the annual Medicaid Reconciliation Report, fee-for-service (FFS) primary care services claims that are approved through the claims system. In order for this to occur, all FFS primary care services must be submitted and processed through the Medicaid Claims Processing (CP) System. (Refer to the primary care services defined previously in this chapter.) Every individual provider or electronic biller (the billing agent) receives a remittance advice (RA) for services that are billed. The RA informs the provider of the action taken on claims. It is the responsibility of FQHC providers to monitor claim activity and take appropriate steps to resolve pended and rejected claims prior to the final reconciliation. (Refer to the Billing and Reimbursement for Professionals Chapter of this manual for additional billing information.)

For non-primary care services, the FQHC will receive the Medicaid FFS amounts or the amount agreed to with the MHP or SHP as payment in full. The FQHC may enter into a risk contract with the MHP or SHP for services not included in the primary care definition. Non-primary care services and risk contracts will not be reconciled and are not included in the Medicaid Reconciliation Report.

5.2 RECONCILIATION OF MHPS AND CSHCS SHPS

The FQHC must file an FQHC Medicaid Reconciliation Report with the MDCH HHPRD and must indicate:

- The number of primary care member months.
- The number of primary care visits for beneficiaries with only Medicaid coverage.
- The number of primary care visits for beneficiaries with dual Medicare and Medicaid coverage.
- The amount of primary care payments from MHPs or SHPs; and
- All other payments from MHPs or SHPs.

The FQHC must, upon request, forward a copy of its MHP or SHP contract to the MDCH HHPRD.

MDCH will reimburse the difference between the FQHC PPS rate and the MHP or SHP payments. The contract and all FQHC services are subject to audit and review.

5.3 RECONCILIATION OF QUARTERLY ADVANCES

Quarterly advances are included as Medicaid revenue on the Medicaid Reconciliation Report and are reconciled with the FQHC PPS. The quarterly payment will be made on the RA at the beginning of each quarter.

Quarterly advances are an estimate of the difference between the payments that a MHP, CSHCS SHP, Substance Abuse Coordinating Agency, and the Healthy Kids Dental contractor, make to the FQHC, and the payments the FQHC would have received under the PPS. This quarterly amount may be adjusted periodically by MDCH to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to FQHCs. The FQHC may request a change in the quarterly payment through the HHPRD.

5.4 Reconciliation of Transportation

Medicaid transportation is paid at actual cost up to the Federal mileage reimbursement rate. Medicaid transportation is paid annually with the reconciliation. Documentation of the actual mileage must be provided on the Medicaid Reconciliation Report. Transportation requirements are defined in the Benefits Section of this chapter.

5.5 Prospective Payment Per Visit Rate

An FQHC is reconciled to the prospective payment per visit rate determined under the PPS or the MOA. Under BIPA of 2000, the PPS per visit payment is equal to 100 percent of the average of the FQHC reasonable costs of providing Medicaid services during Fiscal Years 1999 and 2000. The Medicaid per visit amount is an all-inclusive rate that covers all defined primary care services. (Refer to the Reconciliation Report subsection of this section for a definition of reasonable costs.)

5.6 New FQHC Prospective Payment Rate

An entity that initially qualifies as an FQHC after fiscal year 2000 will be paid a per visit amount that is equal to 100 percent of the costs of furnishing primary care services during such fiscal year based on the rates established under the PPS for the fiscal year for other FQHCs located in the same or adjacent area with a similar case load. If there is not another FQHC similarly situated, the newly established FQHC shall be paid a per visit amount based on an estimate of its reasonable costs of providing such services and reconciled at the end of its first fiscal year of operation. (Refer to the Reconciliation Report subsection of this Section for a definition of reasonable costs.)

A newly established FQHC is eligible for quarterly payments. The amount of the quarterly payment will be estimated until the first reconciliation period. In subsequent years, the newly established FQHC shall be paid using the PPS methodology or an alternate MOA methodology.

5.7 PPS Medicare Economic Index Adjustment

The per visit amount is adjusted each year using the Medicare Economic Index beginning January 1, 2002, based on changes in the Medicare Economic Index for the prior calendar year.

5.8 PPS Adjustments in the Per Visit Rate

The per visit rate may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by an FQHC. An adjustment to the per visit rate based upon a change in the scope of services will be prospective. The adjustment may result in either an increase or decrease in the per visit amount paid to the FQHC. (Refer to the Scope of Service subsection of this Section for additional information.)

5.9 Alternative Payment Methodology

Some FQHCs have elected to be reimbursed under an alternative method referred to as the Memorandum of Agreement (MOA). FQHCs signing the MOA will be subject to the terms, conditions, and requirements at the time the MOA was signed by both MDCH and the FQHC. The MOA terms, conditions, and requirements include, but are not limited to, calculation of the prospective payment amount (PPA), PPA

services, adjustment to the PPA for changes in the scope of services, denial of change in PPA, quarterly payments, and settlements.

5.10 Scope of Service

5.10.A. Increase/ Decrease in Scope of Service

The prospective payment rate may be adjusted for an increase or decrease in scope of service.

- An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved FQHC benefits that no current professional staff is licensed to perform.
- A decrease in scope of service results when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

An increase or decrease in scope of service does **not** result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

- An increase, decrease or change in number of staff working at the clinic.
- An increase, decrease or change in office hours.
- An increase, decrease or change in office space or location.
- The addition of a new site that provides the same set of services.
- An increase, decrease or change in equipment or supplies.
- An increase, decrease or change in the number or type of patients served.

5.10.B. Notice of Intent to Change Scope of Service

If an FQHC intends to change its scope of service, the MDCH HHPRD must be notified 90 days before any financial commitments (i.e., money paid or committed to be paid, contracts signed, etc.) have been made. It is the responsibility of the FQHC to notify MDCH for an increase or decrease in scope of service. Notification should include the following documentation:

- A complete description of the service to be changed (addition or deletion).
- A listing of procedure codes to be billed as a result of this new service.
- A budget for the fiscal year showing an estimate of the total increase or decrease in cost resulting from change.
- An estimate of the change in number of visits.
- Estimates of the cost change on the current Medicaid per visit rate.
- The proposed customary charges for this service by the clinic.

- The customary charges for this service by other providers in the area served by this clinic.
- The amount to be paid by a MHP for this service for various programs (Medicare/Medicaid).
- Medicare fee screen for this service for non-PPS providers.
- The current Medicare visit rate.
- Total encounters for last two years by program (Medicaid, Medicare, uninsured, etc) and type (MHP, fee screen, contracted amount).
- Estimated increase in encounters by program for two fiscal periods following the change in scope of service.
- Copies of notices, certifications, applications, approvals and other documentation from Michigan Department of Consumer and Industry Services (DCIS), CMS, Medicare intermediary, or other organizations documenting the change in scope of service.
- Other information showing cost, visits or approvals/denials of the change.
- Other information as requested by HHPRD.

After a review of the information submitted, HHPRD determines if a per visit rate change will be made and notifies the FQHC, specifying the effective date of any change. All scope of service changes are made on a prospective basis.

5.11 Reconciliation Report

Each FQHC must complete an FQHC Medicaid Reconciliation Report for its fiscal year. The MDCH HHPRD must receive the report by the due date for the Medicare Cost Report in order for the FQHC to receive PPS reimbursement.

The FQHC's authorized individual who certifies the report and accompanying worksheets for the period noted must sign its FQHC Medicaid Reconciliation Report. If the required report and supplemental documents are not submitted within the required time limit, the FQHC waives its rights to PPS reimbursement for that year.

The FQHC Medicaid Reconciliation Report must be for the same fiscal period and cover the same sites as the Medicare Cost Report.

5.11.A. Reasonable Costs

Reasonable and allowable costs are defined as the per visit amount approved and paid by Medicare or as defined in an MOA.

5.11.B. Maintenance Of Medical And Financial Records

The FQHC must maintain, for a period of not less than six years, financial and clinical records for the period covered by the reconciliation report that are accurate and in sufficient detail to substantiate the cost data reported. The records must be maintained

until all issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC or the expenses will be disallowed.

The MDCH HHPRD will maintain each required FQHC Medicaid Reconciliation Report submitted by the provider for six years following the date of submission of the report. In the event that there are unresolved issues at the end of this six-year period, the report will be maintained until such issues are resolved.

The financial and clinical records of the FQHC must be available for review by authorized personnel or agents of MDCH, the Health Care Fraud Division of the Michigan Department of Attorney General, and US Department of HHS in conformity with the provisions of the Social Security Act.

SECTION 6 – AUDITS, RECONCILIATIONS AND APPEALS

6.1 QUARTERLY ADVANCES AND RISK CONTRACTS

The FQHC's quarterly advances will be reconciled annually on the reconciliation report. Risk contracts will not be reconciled.

6.2 RECONCILIATION AND SETTLEMENTS

6.2.A. INITIAL SETTLEMENTS OF FQHCS

An initial settlement is calculated annually. Calculations are determined from the filed FQHC Medicaid Reconciliation Report and Medicaid paid claims information. An initial settlement will be completed generally within three months of the receipt of a complete and acceptable reconciliation report. MDCH retains the right to withhold a portion of an initial payment based on individual circumstances.

6.4.B. FINAL SETTLEMENTS OF FQHCS

Final settlements for FQHCs are completed generally within one year of the FQHC fiscal year end using updated Medicaid data for the period covered by the FQHC Medicaid Reconciliation Report. This will allow sufficient time for all claims to clear the Medicaid payment system. Medicaid data will be updated using approved claims payment data, all other payments for Medicaid services, and Medicaid visits.

The Medicare intermediary field and/or desk audit may cause MDCH to process an additional final settlement. After review of the revised cost report and any statistical and audit findings pertaining to it, MDCH may process a revised Medicaid final settlement for the period covered by the reconciliation report.

6.4.C. UNDERPAYMENTS TO FQHCS

MDCH staff process the full amount of the final settlement through a gross adjustment.

6.4.D. OVERPAYMENTS TO FQHCS

Once a determination of overpayment has been made, the amount determined is a debt owed to the State of Michigan and shall be recovered by MDCH. The recovery will start approximately 30 days after notification to the FQHC. A credit gross adjustment will stop all payments to the FQHC physician(s) until the amount is recovered. This amount will be reflected on the Remittance Advice (RA).

Any issues left unresolved due to the Medicare audit and/or Medicare adjustment process must be appealed through the proper Medicare process before any changes can be made to the Medicaid settlements.

6.5 Response to the Audit Adjustment Report

MDCH staff prepares the Audit Adjustment Report, which contains a descriptive list of all Medicaid data adjustments made to the Medicaid Reconciliation Report by MDCH audit staff. The Audit Adjustment Report must be accepted or rejected by the FQHC within 30 calendar days of its mailing date.

The FQHC may take the following actions:

FQHC Accepts the Report	If the FQHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the FQHC must sign the report and mail it to the MDCH HHPRD. (Refer to Directory Appendix for contact information.) A Notice of Amount of Program Reimbursement will be mailed to the FQHC. No further administrative appeal rights will be available for the adjustments contained in the Audit Adjustment Report.
FQHC Does Not Respond	If the FQHC does not respond within this time period, MDCH shall issue a Notice of Amount of Program Reimbursement, which is the final determination of an adverse action. No further administrative appeal rights are available.
FQHC Rejects the Report	If the FQHC rejects any or all of the findings contained in the Audit Adjustment Report, the FQHC may request a Post-Audit Conference within 30 calendar days from the date of receipt of the Audit Adjustment Report.

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the reporting period under consideration.

6.6 Medicaid Appeals

Medicaid providers have the right to appeal any adverse action taken by MDCH unless that adverse action resulted from an action over which the MDCH had no control (e.g., Medicare termination, license revocation). The appeal process is outlined in the General Information for Providers Chapter of this manual and in the MDCH Medicaid Provider Reviews and Hearings rules, R400.3401 through R400.3424, filed with the Secretary of State on March 7, 1978. Any questions regarding this appeal process should be directed to the Administrative Tribunal. (Refer to the Directory Appendix for contact information.