MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 27, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER – 2900

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2900 – Federally Qualified Health Centers (FQHC) are being proposed to create a new MSM Chapter for currently covered and non-covered FQHC services. Language was moved from MSM Chapter 600 and clarifying information was added.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Provider Type (PT) 17, Specialty 181.

Financial Impact on Local Government: N/A

These changes are effective October 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL Federally Qualified Heath Centers (FQHC)	MTL Federally Qualified Health Centers (FQHC)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2900	**Policy**	Moved language from MSM Chapter 600, Section 605 to define FQHCs.
2901	**Authority**	Added “Authority” language.
2902	**Reserved**	Added “Reserved” section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2903	**Health Services**	Moved language from MSM Chapter 600, Section 605.1. Language added to define "encounter." Added "Registered Dietitian" to the list of providers. Added language for laboratory and radiology services for clarification of allowed services. Added telehealth services provided.
2903.1	**Non-Covered Services**	Language moved from MSM Chapter 600, Section 605.1.
2903.2	**Ancillary Services**	Language moved from MSM Chapter 600, Section 605.2. Added clarifying language for Ancillary Services.
2903.3	**Medical Necessity**	Moved from MSM Chapter 600, Section 605.3.
2903.4	**Service Limitations**	Added language for Service Limitations.
2903.5	**Prior Authorizations**	Moved from MSM Chapter 600, Section 605.4 and added language for Prior Authorizations.
2904	**Hearings**	Added language for Hearings procedures.

2900~~605~~ FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) are defined by the Health Resources and Services Administration (HRSA) as health centers providing comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. Nevada Medicaid reimburses for medically-necessary services provided at FQHCs and follows State and Federal laws pertaining to them.

2901 AUTHORITY

A. Medicaid is provided in accordance with the requirements of Title 42 Code of Federal Regulation (CFR) Part 440, Subpart A – Definitions, Subpart B and Sections 1861, 1929(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Social Security Act (SSA) and Section 1461 of the Omnibus Budget Reconciliation Act of 1990. Physician's services are mandated as a condition of participation in the Medicaid Program Nevada Revised Statute (NRS) 630A.220.

B. The State Legislature sets forth standards of practice for licensed professionals in the NRS for the following Specialists:

1. Section 330 of the Public Health Service (PHS) Act;
2. NRS Chapter 630 – Physicians and Physician Assistants and Practitioners of Respiratory Care General Provisions;
3. NRS Chapter 633 – Osteopathic Medicine;
4. NRS Chapter 635 – Podiatry;
5. NRS Chapter 640E – Registered Dietitians;
6. NRS Chapter 450B – Emergency Medical Services;

2902 RESERVED

2903~~605.1~~ HEALTH SERVICES

A. The Division of Health Care Financing and Policy (DHCFP) reimburses FQHCs an outpatient encounter rate.

1. For the purposes of reimbursement, an encounter is defined as:

   a. A face-to-face "visit" or an "encounter" between a patient and one or more approved licensed Qualified Health Professional or other Medicaid Qualified Provider that takes place on the same day with the same patient for the same service type; this includes multiple contacts with the same provider.

2. Providers approved to furnish services included in the outpatient encounter are:

   a. Physician or Osteopath;

   b. Dentist;

   c. Advanced Practice Registered Nurse (APRN);

   d. Physician Assistant;

   e. Certified Registered Nurse Anesthetist (CRNA);

   f. Certified Registered Nurse Midwife;

   g. Psychologist;

   h. Licensed Clinical Social Worker;

   i. Registered Dental Hygienist;

   j. Podiatrist;

   k. Radiology;

   l. Optometrist;

   m. Optician;

   n. Registered Dietitian; and

o. Clinical Laboratory

3. Approved encounter services include:

a. Primary care services medical history, physical examination, assessment of health status, treatment of a variety of conditions amendable to medical management on an ambulatory basis by an approved provider and related supplies;

1. Vital signs including temperature, blood pressure, pulse, oximetry and respiration;

2. Integral laboratory and radiology services conducted during the visits are included in the encounter as they are built into the established encounter rate and are not to be separately billed.

b. Early periodic screenings (Refer to Medicaid Services Manual (MSM) Chapter 1500 – Healthy Kids), for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening policy and periodicity recommendations;

c. Preventive health services recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and education (Refer to MSM Chapter 600 – Physicians Services, Section 606; ~~Attachments #6-12 through #6-14 for preventive services policy);~~

d. Home visits;

e. Family Planning services including contraceptives;

Up to two times a calendar year, the FQHC may bill for additional reimbursement for family planning education on the same date of service as the encounter. (See Billing Guide for more information).

f. For women: annual preventive gynecological examination, prenatal and post-partum care, prenatal services, clinical breast examination, thyroid function test;

g. Vision and hearing screening;

h. Dental office visits;

1. Dental encounters are to be billed as applicable with the FQHC encounter reimbursement methodology.

2. An FQHC may bill a dental encounter for each face-to-face encounter.

3. Dentures provided by an FQHC are included in the daily encounter rate unlike the denture policy established in MSM Chapter 1000 – Dental.

4. Medicaid will pay for a maximum of one emergency denture reline and/or a maximum of six adjustments (dental encounters) done not more often than every six months, beginning six months after the date of partial/denture purchase. A prior authorization is not required for relines. The FQHCs in-office records must substantially document the medical emergency need. Denture/partial relines and adjustments required within the first six months are considered prepaid with the Medicaid's dental encounter payment for the prosthetic.

5. The FQHCs in-office records must substantially document the medical emergency need.

6. See MSM Chapter 1000 for all other covered and non-covered dental services.

i. Telehealth

1. An FQHC may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services (i.e. consult with specialist). If for example, the originating site and distant site are two different encounter sites, the originating encounter site must bill the telehealth originating Healthcare Common Procedural Coding System (HCPCS) code and the distant encounter site may bill the encounter code.

2903.1 NON-COVERED SERVICES

A. Non-covered services under an FQHC encounter:

1. Group Therapy;

2. Eyeglasses;

3. Hearing Aids;

4. Durable medical equipment, prosthetic, orthotics and supplies; and

5. Ambulance services.

2903.2~~605.2~~ ANCILLARY SERVICES

A. Ancillary services are those services which are an approved Nevada Medicaid State Plan service but are not included within an approved FQHC encounter.

1. Ancillary services may be reimbursed on the same date of service as an encounter by a licensed qualified health professional or other Medicaid qualified provider.

2. The FQHC must enroll within the appropriate provider type and meet all the MSM coverage guidelines for the specific ancillary service.

2903.3~~605.3~~ MEDICAL NECESSITY

A. To receive reimbursement, all services provided must be medically necessary as defined in MSM Chapter 100 – Medical Program.

2903.4 SERVICES LIMITATIONS

A. Encounters are categorized as:

1. Medical.

2. Mental/behavioral health.

3. Dental.

B. An FQHC may reimburse for up to three service specific visits per patient per day provided that the FQHC has separate established rates for each encounter type.

2903.5~~605.4~~ PRIOR AUTHORIZATIONS

A. FQHC encounters do not require prior authorizations, Prior Authorization (PA) requirements indicated in reference to MSM Chapters are not valid when the service is performed as an FQHC encounter. However, the patient file must contain documentation supporting medical necessity of services provided.

B. Ancillary services billed outside of an encounter must follow prior authorization policy guidelines for the specific services provided.

For billing instructions for FQHCs, please refer to the Billing Manual for Provider Type 17.

For Indian Health Programs (IHP) policy, please refer to MSM Chapter 3000, Indian Health.

2904 HEARINGS

A. Please reference Nevada Medicaid Services Manual (MSM) 3100 for hearings procedures.