West Virginia Children's Health Insurance Program

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Prospective Payment System (PPS) Policy

The West Virginia Children's Health Insurance Program (WVCHIP) provides quality health insurance coverage to children up to age 19 and pregnant women 19 years and older in families whose income disqualifies them from coverage available through the WV Medicaid, but is less than or equal to 300% of the current Federal Poverty Level (FPL), and have no other health insurance coverage. Benefits include medical, behavioral health, dental, vision, and drug coverage. WVCHIP operates independently of the state's Medicaid Program.

Section 503 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandated that "separate" CHIP programs pay Federally Qualified Health Centers (FQHC), FQHC "look-alikes", and Rural Health Clinics (RHC) under a prospective payment system (PPS). This PPS provides for per-visit rates (encounter rates) based on each center's reasonable costs, annually trended by the Medicare Economic Index (MEI). West Virginia Children's Health Insurance Program, FQHC/RHC Prospective Payment System (PPS) Policy was established in 2011 and is updated in this document.

Eligible Organizations

To be eligible for reimbursement under PPS, organizations must be either a FQHC, RHC, or a FQHC look-alike in accordance with the requirements of the Health Resources and Services Administration (HRSA) for FQHCs and the Centers for Medicare and Medicaid Services (CMS) for RHCs. New organizations must enroll with WVCHIP and submit documentation from their HRSA grant and/or CMS certification of their status to WVCHIP or its vendor. Organizations must notify WVCHIP immediately if they no longer meet FQHC or RHC status, experience a name change, a change in Tax Identification Number (TIN), a change in CMS Certification Number (CCN), or a change in ownership.

Initial Interim PPS Rates for New Organizations

New organizations are assigned an initial interim PPS rate after documents listed below are submitted.

Documents required for FQHC's	**Documents Required for RHC's**
HRSA Grant – Copy	Medicare Approval letter
Corporate Ownership NPI	Corporate Ownership NPI
Name of Clinic or Location with NPI	Name of Clinic or Location with NPI
Location Address	Location Address
Contact Person's Name and Number	Contact Person's Name and Number

Initial interim rates are based upon the statewide average PPS rates of all organizations that submitted cost reports for WVCHIP PPS base years (2006 and 2007), who are within the same "peer group" (FQHCs (and FQHC look-alikes), free-standing RHCs, and provider-based RHCs), excluding the lowest and highest rates, and trended forward annually by the MEI. New organizations will be notified of the assigned initial interim PPS rate and effective date by Certified Mail or email (if on file) from WVCHIP's vendor.

Secondary Interim Rates for New Organizations

A secondary interim PPS rate is established based on the organization's first full-year actual Medicare cost report. The purpose of the secondary interim PPS rate is to replace the initial interim PPS rate based on the statewide average with an interim PPS rate based on an organization's actual costs. The secondary interim PPS rate will be effective until the second full-year Medicare cost report is provided and a final PPS rate can be established. The following documentation must be submitted to WVCHIP or their vendor to establish the secondary interim PPS rate:

1. First full-year Medicare cost report
    - Hard copy signed by the facility administrator or appropriate personnel
    - Electronic Cost Report (ECR) file, if available
2. Detailed working trial balance corresponding to the cost report, including a crosswalk, or mapping that shows how costs are classified into cost report cost centers
3. Documentation in support of cost report reclassifications and adjustments
4. Documentation in support of cost report full-time equivalents (FTEs) and visits

Final PPS Rate for New Organizations

Final PPS rates are based on the Medicare cost reports for the organization's first two complete fiscal years of operations. For example, if a clinic becomes a RHC on October 1, 2015 and has a December 31 fiscal year end, the final PPS rate will be established using the provider's FYE 12/31/2016 (first full-year) and 12/31/2017 (second full-year) Medicare cost reports. The PPS rates are calculated as the average cost-per-visit of the desk reviewed and adjusted cost reports. The WVCHIP PPS rate development does not consider Medicare rate caps or Medicare productivity screens. To establish the final PPS rate, the following documentation must be submitted to WVCHIP:

1. Second full-year Medicare cost report
    - Hard copy signed by the facility administrator or appropriate personnel
    - Electronic Cost Report (ECR) file, if available
2. Detailed working trial balance corresponding to the cost report, including a crosswalk, or mapping that shows how costs are classified into cost report cost centers
3. Documentation in support of cost report reclassifications and adjustments
4. Documentation in support of cost report full-time equivalents (FTEs) and visits

Effective Dates

WVCHIP PPS became effective October 1, 2009. For new organizations, PPS encounter rates are effective the first day of the month following the facility's effective date reflected

on either the approved HRSA grant for FQHC's or Medicare's RHC Approval letter or the date of request to enroll as a provider with WVCHIP, whichever is later. In instances that the provider was untimely in submitting any related documentation necessary to set the PPS rate, the effective date will be the first day of the calendar year after the cost reports would have normally been available under the typical Medicare 56-month filing limit.

Annual Rate Adjustments

On January 1 of each year, interim and final PPS rates are inflated using the MEI. The MEI is published annually in the Federal Register.

PPS Rate Assignment for Organization's Addition of New Locations

At times, an organization will add new clinic locations. When this occurs, the Organization itself works with either HRSA or Medicare to receive approval of the additional clinic site. A "corporate owner" that is currently in an approved PPS Rate plan relationship with WVCHIP enrolls a new location or site and requests an assigned a PPS Rate with WVCHIP by submitting notification to the WVCHIP and/or it's rate setting vendor for consideration as an active addition to the corporation's PPS rate assignment. If qualified, the additional location site must have its own NPI # and will be assigned the organizations established rate. The organization must disclose and identify itself as the corporate organization with a location or site operating as "doing business as" (dba) type arrangement.

Encounters

A billable patient visit, or "encounter", is the fundamental element of the PPS reimbursement structure. With the exception of services that are carved-out of the PPS rate (e.g., lab, radiology, etc.), PPS reimbursement is driven by the provision of a face-to-face encounter between a patient and a clinic or center practitioner. Services that do not constitute a billable encounter are those services that do not meet the definition of an "encounter".

An encounter is a face-to-face visit between a WVCHIP member and an eligible practitioner that is exercising independent professional judgement within the scope of their license as listed below:

- Physician
- Physician Specialists
- Physician Assistant
- Nurse Practitioner
- Advanced Practice Registered Nurse (APRN)
- Registered Nurse
- Visiting Nurse
- Licensed Clinical Psychologist
- Licensed Independent Clinical Social Worker
- Licensed Graduate Social Worker
- Licensed Clinical Social Worker

- Licensed Professional Counselor
- Dentist
- Dental Hygienist
- Chiropractor
- Podiatrist
- Ophthalmologist
- Optometrist
- Physical, Occupational, Respiratory, or Speech therapist
- Audiologist

Encounters are recognized for payment when they take place in the following settings:

Place of Service Code	Place of Service Description
03	School (school-based location must be FQHC/RHC
11	Office
12	Home
31	Skilled Nursing Facility (SNF)
32	Nursing Facility
50	FQHC
72	RHC

Providers must bill the appropriate place of service code on each claim in order to receive the encounter rate. Services performed outside these settings do not meet the definition of an encounter and are not eligible for encounter rate reimbursement. Examples are services provided by clinic practitioners to WVCHIP members in inpatient or outpatient hospital settings. If these services are provided and are a covered benefit under the WVCHIP, they may be billed and paid outside the PPS encounter rate using WVCHIP fee schedules. Additionally, because under Medicare cost reporting guidelines providers are not to include on the cost report such services rendered in non-FQHC/RHC settings, these costs are not included in the PPS encounter rate.

Appendix I lists services that are included in the definition of an encounter. In summary, a billable encounter is a face-to-face visit with a practitioner type listed above, in a place of service included on chart above, and involves services outlined in Appendix I.

Incident-to Services

Encounter rates include payments for services and supplies related to the patient visit, including supplies or services considered “incident – to” the professional service provided during the encounter. “Incident-to” services are defined as services and supplies considered to be an integral part of the service, are commonly furnished in a physician’s office, commonly rendered without charge or included in the bill, supplies defined within the procedure code definition, furnished under the supervision of the health care professional, and rendered by a staff member of the center or clinic. “Incident – to” services are typically not recognized as encounters and are not separately reimbursable. These services include blood pressure measurement, blood draws for lab services, height/weight measurement, medical supplies or disposable medical products, sample medications not provided through a prescription, drugs or biologicals that cannot be self-administered, obtaining blood or urine samples, and any service or supply considered “incident-to” a professional service, or services provided

under the supervision of an eligible practitioners listed in this document. Incident-to services also include services that the FQHC or RHC commonly furnish without charge.

Pass-Through Services

Certain types of services are excluded from the encounter rates and are reimbursed under the WVCHIP fee-schedule. These are referred to as pass-through services and include laboratory and radiology services (7000 and 8000 codes), durable medical equipment, and prosthetic devices. Prescription drugs are excluded from encounter rates to the extent that the center or clinic has an in-house pharmacy that bills for pharmacy services separately through the point-of-sale. For centers or clinics without an in-house pharmacy, the costs of the dispensing physicians are included in the encounter rate. Also, except for "incident-to" services that are included in the PPS rate and not separately billable, any service listed as a WVCHIP covered benefit provided by the center or clinic that does not meet the definition of a billable encounter is a "pass-through" service.

Inpatient or Outpatient Hospital Services and Settings

Services provided in inpatient or in outpatient hospital settings and are a covered benefit under the WVCHIP are pass-through services. For claim reimbursement purposes, the facility must also be an approved provider location with WVCHIP. Additionally, because Medicare cost reporting guidelines providers are not to include on the cost report such services rendered in non-FQHC/RHC settings, these costs are not included in the PPS encounter rate.

Encounter Restrictions and Limitations

An FQHC may bill for up to three separate encounters per member occurring in one day:

- One medical encounter,
- One behavioral health encounter, and
- One dental encounter.

Encounters with more than one eligible practitioner or multiple encounters with the same eligible practitioner that take place on the same day, at a single location, and that have the same diagnosis, constitute a single encounter, except when one of the following occurs:

- After the first encounter, the patient suffers a different illness or injury requiring additional diagnosis or treatment.
- The patient has a medical visit, a behavioral health visit, or a dental visit on the same day.

An Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV) is considered an FQHC or RHC encounter. However, if it is provided in conjunction with another service, it may not be billed separately

The medical necessity of multiple encounters must be clearly documented in the medical record. Providers must exercise caution when billing for multiple encounters on the same day, and such instances are subject to post-payment review to determine the validity and appropriateness of multiple encounters. Providers may not inappropriately generate multiple encounters by unbundling services that are routinely provided together during a single visit or scheduling multiple patient visits for services that could be performed at a single visit. One example of this scenario is a member requiring the fillings of 3 dental carries and the provider schedules 3 visits, one for each filling, as opposed to completing the number of appropriate fillings in one visit.

Telehealth

FQHCs and RHCs can be either originating or distant sites for telehealth. When the FQHC or RHC is the originating site (where the patient is located), and no other services for the member are provided that day, a telehealth originating site facility fee may be billed using code Q3014. If additional evaluation and management services are provided during the visit, the FQHC or RHC may bill the encounter code as appropriate. The originating site facility fee will not be reimbursed on the same day for the same member as an encounter rate. If the FQHC or RHC is providing service as a distant site (where the provider is located) through appropriate telehealth technologies, the visit is considered a face-to-face encounter and the encounter rate is reimbursable for that visit. Please refer to WVCHIP's Telehealth Policy for more information.

Copayments

Payment under the PPS Rate Policy does not supersede or preclude the collection of member copayments. Providers should collect the appropriate copayment for which the member is responsible. Copayments are waived when WVCHIP members receive services from their medical homes. Please refer to the WVCHIP Summary Plan Description for more information WVCHIP medical home policy. WVCHIP deducts the member's copayment amount from its reimbursement.

Change in Scope of Service

The PPS rate may be adjusted in the event the FQHC or RHC experiences an increase or decrease in the type, intensity, duration, and/or amount of services (a "qualifying event") provided by the center/clinic. A change of scope of services applies only to WVCHIP covered services. Note: A change in costs alone does not constitute a change in scope of service.

A change in scope of services related to the provision of WVCHIP covered services may be recognized for a recalculation of the clinic's/center's rate if the clinic/center implements a qualifying event. The following events implemented by a clinic/center shall be considered a qualifying event:

- Addition of a facility that is not present in the existing PPS rate. Relocation or renovation of a current facility present in the existing PPS rate is not a qualifying event

- Closure of a facility that is present in the existing PPS rate. Facility closures increasing the encounter rate will not be deemed as a qualifying event. Facility closures decreasing the encounter rate may be deemed as a qualifying event
- Deletion of a service that is present in the existing PPS rate. Deletion of services increasing the encounter rate will not be deemed as a qualifying event. Deletion of services decreasing the encounter rate may be deemed a qualifying event
- A change in service resulting from federal or state regulatory requirements specific to FQHCs and/or RHCs
- Addition of a WVCHIP covered service that is not present in the existing PPS rate. Increases or decreases in patient volume for an existing service is not a qualifying event.

The following criteria must be met for a facility to qualify for a rate adjustment due to a change in scope of service:

- The change in scope of service must have been implemented continuously for six consecutive months.
- The cost attributable to a change in the scope of service, on a cost-per-visit basis, must account for an increase or decrease to the PPS rate effective at the start date of the qualifying event of 5% or greater. To determine if the 5% threshold is met, the cost-per-visit specifically attributable to the qualifying event will be divided by the PPS rate in effect when the change in scope was implemented.
- The costs relating to the change in the scope of service complies with Medicare reasonable cost principles.

The organization must submit a change in scope review request in writing on company letterhead to the WVCHIP. The request must clearly specify the qualifying event and implementation date. The facility must submit a copy of the Medicare cost report, and a detailed trial balance, for the cost reporting period in which the end of the six-month implementation period falls, and all other information necessary as requested by WVCHIP.

If a change in scope of service is known in advance or planned, the facility should notify the WVCHIP as soon as possible prior to the change in scope of service. Otherwise the facility must notify the WVCHIP and submit the request for a change in scope of services review as soon as possible after the change in scope occurs. Providers must at a minimum submit the request for a change in scope of services review to the WVCHIP by the last day of the third month after the change in scope has been implemented for six consecutive months (a maximum of 9 months from the change in scope implementation). If the request is not submitted in the specified time frame, the PPS rate will be effective on a prospective basis only beginning on the first day of the calendar year following the calendar year in which the provider notifies the WVCHIP of the change in scope of services.

Reviews for a change in scope of services will take place within 90 days of the receipt of all required documentation. The WVCHIP or it's vendor will review the request, and all submitted documentation for completeness, accuracy, and compliance with change in scope of service policies. Based upon a review of the documentation and any other

relevant information, the WVCHIP or it's vendor will notify the provider of the results of the review and whether an adjustment to the PPS rate is warranted.

If it is determined that a change in scope meets standards, and a PPS Encounter rate adjustment is warranted, the cost-per-visit that is directly attributable to the CIS of service will prompt a recalculation of the provider's PPS Encounter rate. The new Encounter Rate's effective date will be six months after the CIS was implemented. The new PPS rate will be effective on the first day of the calendar year following the fiscal year in which the change in scope was in effect for six consecutive months. If a change in scope of service is not filed within the appropriate timeframe, the adjusted PPS rate will be effective on a prospective basis only, beginning on the first day of the calendar year following the calendar year in which the provider notifies the WVCHIP of the change in scope of services.

Change in Scope of Service Example

An organization experienced a qualifying event because of the addition of dental services to the current list of services provided. The organization began offering dental services on October 1, 2015. The organization submitted a change in scope of services request to the WVCHIP in a timely manner. The notification requirements would be satisfied by either of the following:

- The provider notifies the WVCHIP in writing no later than October 1, 2015 that the clinic will begin dental services at the facility.
- The provider notifies the WVCHIP in writing no later than June 30, 2016 that the clinic began providing dental services (the last day of the third month after the change in scope has been implemented for six consecutive months).

Additional assumptions for this example are the following:

- The costs attributable to the qualifying event (addition of dental services) were $80,000, consisting of salaries of $60,000, other expenses of $10,000, and overhead of $10,000.
- The costs attributable to the qualifying event are divided by total visits to determine the cost-per-visit impact of the scope change, $8.00.
- The provider's PPS rate at the time the qualifying event had been implemented for six consecutive months was $110.00.
- The clinic has a December 31 fiscal year end.

Because the provider's fiscal year ends on December 31, the cost reporting period in which the end of the six-month implementation period falls is the provider's fiscal year ending December 31, 2016. The provider must submit a copy of the Medicare cost report (and a detailed trial balance) for the fiscal year ending December 31, 2016. Incorporating the above assumptions, below is an example calculation of a change in scope calculation utilizing the provider's FYE 12/31/2016 cost report:

	As-Filed Cost Report	Cost Report Without Change in Scope	Costs & Visits Attributable to Change
Allowable Costs	$ 1,200,000	$ 1,020,000	$ 80,000
Visits	10,000		10,000
Cost Per Visit	$ 120.00		$ 8.00

In this example, the change in scope had been implemented for six consecutive months on April 1, 2016 (6 months after the clinic began providing dental services); therefore, the PPS rate used in the calculation would be the PPS rate in effect on April 1, 2016. The cost per visit specifically relating to the scope change ($8.00) is divided by the PPS rate at the time the scope change was in effect for 6 consecutive months (2016 PPS rate of $110.00) to determine if the 5% threshold is met. Because the 5% threshold is met in this example ($8.00 / $110.00 = 7.27%), the clinic qualifies to receive a PPS rate adjustment resulting from the change in scope of services (addition of dental services).

The incremental cost-per-visit attributable to the change in scope of service ($8.00) will be added to the center or clinic PPS rate in effect at the time the change in scope was in effect for 6 consecutive months. The 2016 PPS rate of $110.00 will be increased by $8.00, resulting in a new PPS rate due to the change in scope of services of $118.00. Assuming the request was filed in a timely manner, this new rate will become effective the first day of the calendar year following the fiscal year in which the change in scope of services has been implemented continuously for six consecutive months (January 1, 2017).

2016 PPS Rate	Change in Cost Per Visit	% Increase or Decrease	5% Threshold Met	Adjusted PPS Rate on 1/1/2017
$ 110.00	$ 8.00	7.27%	Yes	$118.00

APPENDIX's I, II, III, IV

West Virginia Children's Health Insurance Program

Billing Instructions for Federally Qualified Health Center (FQHC's) and Rural Health Centers (RHC's) Under a Prospective Payment System

Encounter-Eligible Service Claims Information

FQHC's and RHC's may submit claims for medical and/or behavioral health services provided to WVCHIP members on paper UB04 or CMS 1500 forms or electronic 837P claim forms. Dental claims should be filed using the 2006 ADA claim form. Claims must be filed within six (6) months from the date of service to meet WVCHIP timely filing rules. **The encounter code, T1015, must be listed on line 1 of the claim with total claim charges, excluding charges for pass-through services, and the specific procedure code(s) provided during the encounter with $0.00 charge must be listed one the remaining lines for the claim to process.** Centers must list the appropriate modifier with the T1015 code to distinguish the type of visit. The list of appropriate modifiers is in Appendix III. Claims with only T1015 listed and no other services will be denied. Claims for encounters submitted without the T1015 code will be denied.

Include only one encounter per claim. Claims with more than one encounter listed will be denied. When billing for more than one encounter per day, **submit one claim for each encounter**. *To indicate a claim is a separate encounter, enter "unrelated diagnosis" and the time of both visits in field 19 on the 1500 Claim Form or in the Comments field when billing electronically.* Documentation for all encounters must be included in the member's file.

Pass Thru Eligible Service Claims Information

Claims for "pass-through" services and supplies may be billed with or without the encounter code T1015 listed on the claim. If listing "pass-through" codes in addition to the encounter, please include full charges for the "pass-through" service on the line with the "pass-through" code and be sure to exclude these charges from the T1015 line.

The following CMS-1500 Claim Form instructions relate to FQHCs and RHC':

Field No.	Name	Entry
24B	Place of Service	Enter one of the valid place of service codes
24J	Rendering Provider ID#	Enter the service-specific taxonomy code
33B	Physician's or Supplier's Billing Name, Address, Zip Code and	Enter your billing pay to NPI # and FQHC taxonomy code 261QF0400X or RHC taxonomy code

APPENDIX II

Services Included in Encounter Rates

Procedure codes and services listed in this appendix are those typically included within payment for an encounter. This is not an all-inclusive list. Determination of inclusion within an encounter payment for a service or supply codes is based upon criteria outlined in the 2020 WVCHIP, FQHC/RHC Prospective Payment System (PPS): System Overview Policy and the WVCHIP Covered Benefits.

Evaluation and Management Services			**Preventive Services**
99201	99211	99381	99391
99202	99212	99382	99392
99203	99213	99383	99393
99204	99214	99384	99394
99205	99215	99385	99395

Surgical Services	**10000 - 69999**	
Vaccine Administration	**Multiple Codes**	**WVCHIP purchases vaccines through the Vaccines for Children (VFC) program**
Medical Supplies	**Multiple Codes**	**Supplies integral to the service provided and included in the procedure code definition are included in the encounter rate**
Drugs and Injectables	**J0000 – J9999**	
Medicine	**90281- 90399**	**Immune Globulins, Serum or Recombinant Products**
Psychiatry	**91010 - 91299**	
Gastroenterology	**96010 - 91299**	
Ophthalmology	**92002 - 92499**	
Otorhinolaryngologic	**92502 – 92700**	
Cardiovascular	**92950 – 93799**	
Pulmonary	**94002 – 94799**	
Allergy and Clinical Immunology	**95004 - 95199**	
Endocrinology	**95250 - 95251**	
Neurology and Neuromuscular	**95800 - 96020**	
Central Nervous System Assessments/Tests	**96101 – 96125**	

*** Highly complex drug or Highly Complex Biologic Agency Administration**	**96360 - 96549**	
Physical Medicine and Rehabilitation	**97001 – 97999**	
Chiropractic Manipulative Treatment	**98940 – 98943**	
Home Health Procedures/Services	**99500 – 99602**	
Dental Services	**D-Codes**	

Dental: Dental services and procedures defined by the American Dental Association (ADA), as covered under WVCHIP, and meeting the definition of an encounter. Please see the most recent WVCHIP Dental Provider Guide for covered dental procedures and services at www.wv.chip.gov.

APPENDIX III

Pass-Through Services

Procedure codes and services listed in this appendix are not included in the encounter rate payment and are paid according to WVCHIP fee-schedules. Appendix III is not an all-inclusive list. Determination of exclusion from an encounter payment for service or supply codes is based upon criteria outlined in the WVCHIP FQHC/RHC Prospective Payment System (PPS): System Overview and Policy document located at www.wv.chip.gov and the WVCHIP benefit.

Radiology	**70010 - 79999**
Laboratory and Pathology	**80047 - 89999**
Durable Medical Equipment	**Multiple Codes**
Prosthetic Devices	**Multiple Codes**

Services that do not meet the definition of an encounter or are not included in the encounter are pass-through services.

Appendix IV

Modifiers

The following list of modifiers **must** be listed on the claim with the T1015 code to distinguish the type of visit.

U1	Medical Encounter
U2	Dental Encounter
U3	Mental Health Encounter Required
U4	Physical Therapy Encounter
U5	Speech Therapy Encounter
U6	Podiatry Encounter
U7	Vision Service Encounter
U8	Chiropractic Encounter
GT	Telemedicine

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