TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	4. Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license 5. Visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license 6. Comprehensive Perinatal Services Program (CPSP) practitioner services 7. Licensed clinical social worker who is authorized to practice social work services by the State and who is acting within the scope of his/her license 8. Clinical psychologist who is authorized to practice psychology service by the State and who is acting within the scope of his/her license 9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State and who is acting within the scope of his/her license Audiology, chiropractic, podiatry, and speech therapy are covered optional benefits only for the following beneficiaries: • Pregnant women, if the optional benefit is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic and Treatment benefit. Psychology services are covered in FQHCs for all Medi-Cal beneficiaries.	

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2b. Rural Health Clinic services and other ambulatory services covered under the state plan (continued).	9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license 10 Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State and who is acting within the scope of his/her license Audiology, chiropractic, podiatry, and speech therapy are covered optional benefits only for the following beneficiaries: • Pregnant women, if the optional benefit is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic and Treatment benefit. Psychology services are covered in RHCs for all Medi-Cal beneficiaries. The following services are limited to a maximum of two services in any one calendar month or any combination of two services per month from the following services, although additional services can be provided based on medical necessity: acupuncture, audiology, chiropractic, occupational therapy, podiatry, and speech therapy. Federally required adult dental services are covered in RHCs for all Medi-Cal beneficiaries.	

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2c and 2d Federally Qualified Health Center (FQHC) services and other ambulatory services covered under the state plan (continued).	4. Certified Nurse Midwife (CNM) who is authorized to practice nursing and midwifery services by the State and who is acting within the scope of his/her license 5. Visiting nurse who is authorized to practice nursing by the State and who is acting within the scope of his/her license 6. Comprehensive Perinatal Services Program (CPSP) practitioner services 7. Licensed clinical social worker who is authorized to practice social work services by the State and who is acting within the scope of his/her license 8. Clinical psychologist who is authorized to practice psychology service by the State and who is acting within the scope of his/her license 9. Licensed acupuncturist who is authorized to provide acupuncture services by the State and who is acting within the scope of his/her license 10. Licensed marriage and family therapist who is authorized to provide marriage and family therapist services by the State who is acting within the scope of his/her license Audiology, chiropractic, podiatry, and speech therapy are covered optional benefits only for the following beneficiaries: • Pregnant women, if the optional benefit is part of their pregnancy-related services or services for a condition that might complicate the pregnancy. • Individuals who are eligible for the Early and Periodic Screening, Diagnostic and Treatment benefit. Psychology services are covered in FQHCs for all Medi-Cal beneficiaries.	

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TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
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* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

midwife, clinical psychologist, licensed clinical social worker, **marriage and family therapist,** or visiting nurse, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits under C.I.(a). For purposes of this subparagraph 2(a), "physician" includes the following:

(i) A doctor of medicine or osteopathy licensed by the State to practice medicine and/or surgery and who is acting within the scope of his/her license.

(ii) A doctor of podiatry licensed by the State to practice podiatric medicine and who is acting within the scope of his/her license.

(iii) A doctor of optometry licensed by the State to practice optometry and who is acting within the scope of his/her license.

(iv) A chiropractor licensed by the State in the practice of chiropractic and who is acting within the scope of his/her license.

(v) A doctor of dental surgery (dentist) licensed by the State to practice dentistry and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

(b) Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner.

~~***The elimination of Adult Day Health Care previously scheduled to take place on 3/1/12 (approved via SPA 11-035) has been postponed and will be effective as of 4/1/2012.~~

RHC, the prospective payment reimbursement rate for the first fiscal year was calculated by adding the visit rate for fiscal years 1999 and 2000, and then dividing the total by two.

(b) If the cost per visit for the period(s) used to establish the prospective payment reimbursement rate in subparagraph D.2(a) was calculated using a visit definition that does not conform to Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certify to its authenticity within 90 days after the date written instructions are issued by DH**C**S. DH**C**S must review the revised visit count and supporting documentation supplied by the FQHC or RHC to determine whether a rate adjustment was necessary. This subparagraph D.2(b) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

3. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than ~~20~~ **30** hours per week, or mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when the facility is owned or operated by the same entity, as well as, licensed or enrolled as a Medi-Cal provider.

4. Effective October l 51 of each year, for services furnished on and after that date, DCHS will adjust the rates established under paragraph D.2 by the percentage increase in the MEI applicable to primary care services (as defined in Section 1842(i)(4) of the Act) as published in the Federal Register for that calendar year.

5. DHCS will notify each FQHC and RHC of the effect of the annual MEI adjustment.

E. Alternative Payment Methodology Using the Reported Cost-Based Rate for the Fiscal Year Ending in Calendar Year 2000

An FQHC or RHC that elected the alternative payment methodology under this Section E receives reimbursement under the following provisions:

Each FQHC and RHC that elected to receive payment in an amount calculated using the alternative payment methodology described in this Section E, the rate was effective the first day of the fiscal year that began on or after January 1, 2001. For the period January l, 2001, until the payment methodology described in this Section E became effective for the

For example, if an FQHC or RHC had a June 30th fiscal year end, the period determining the first MEI increase was December 31, 1999 (the FQHC's or RHC's fiscal year mid-point) through April 1, 2001 (the midpoint for the rate period January 1, 2001 through June 30, 2001). The period determining the second MEI increase was April 1, 2001 through February 15, 2002 (the midpoint for the rate period July 1, 2001 through September 30, 2002). If an FQHC or a RHC has a December 31st fiscal year end, the period determining the first MEI increase was June 30, 2000 through April l, 2001. As in the previous example, the period determining the second MEI increase was April I, 2001 through February 15, 2002.

(e) In accordance with Section 1902(bb)(6)(B) of the Act, in order for an FQHC or RHC to receive the rate of payment under the alternative payment methodology, the rate must be no less than the rate calculated using the methodology described in Section D.

2. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than ~~20~~ **30** hours per week or in mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when it is owned or operated by the same entity and is licensed or enrolled as a Medi-Cal provider.

3. Beginning October l, 2002, and each October 1st thereafter, for services furnished on and after October 1, 2002, DH**C**S will adjust the rates established under paragraph E.1, by the percentage increase in the MEI (as specified in subparagraph E.l (c), above).

F. Alternative Payment Methodology for an Existing FQHC or RHC that Relocates

1. An existing FQHC or RHC that relocates may elect to have its prospective payment reimbursement rate re-determined. DH**C**S will establish a rate (calculated on a per-visit basis) that is equal to either of the following (as selected by the FQHC or RHC):

(a) The average of the rates established for three comparable FQHCs or RHCs, as verified by DH**C**S from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph is subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal

(b) Reimbursement at 100 percent of the projected allowable of the facility for furnishing services in the facility's first full fiscal year of the facility's operation at the new site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph D.4.

(c) The per visit rate calculated in accordance with paragraph J.3 (b) above, will be subject to the following:

1. **Minimum productivity standards are used to help determine the average cost per patient for all FQHC or RHC visits reimbursed at the PPS rate. The minimum productivity standards require 3,200 visits per full-time equivalent (FTE) physician and 2,600 visits per FTE nurse practitioner, physician assistant, or certified nurse midwife (NP, PA and CNM). The following healthcare staff are not subject to minimum productivity standards: Dentist, Registered Dental Hygienist (RHD, Doctors of Podiatric (DPM), Doctors of Optometry (OD), Doctors of Chiropractic (DC), Clinical Psychology (CP), License Clinical Social Workers (LCSW), Marriage Family Therapists (MFT), Licensed Acupuncturists, and Comprehensive Perinatal Health Workers.**

   (i) The FTE on the cost report for physicians and NPs, PAs and CNMs is the time spent seeing patients or scheduled to see patients. It does not include non-productive time. Non-productive time is anytime that is spent not seeing patients or scheduled to see patients, such as, administrative time, paid time off (PTO), continuing medical education (CME), and other training and meetings, that occur when the physician, NP, PA or CNM is not seeing patients or scheduled to see patients. All activities related to the provision of health care, such as, but not limited to, reviewing test results, authorizing refills, care-related emails, and follow up calls, are included in the time scheduled to see patients and must be included in the FTE on the cost report.

   (ii) "Administrative time" is defined as time spent on activities related to the overall administration of the clinic, which includes, but may not be limited to, the following types of activities: medical protocol evaluation and implementation, ensuring compliance with state and federal statutes and regulations, resource allocation, utilization review, quality assurance and improvement, planning and administrative meetings, supervisory oversight and coordination between clinic departments, when not scheduled to see or seeing patients, and inventory control.

(iii) The FQHC or RHC is expected to maintain adequate documentation to enable DHCS to verify the time spent seeing patients or scheduled to see patients and non-productive time. The requirement of adequacy of documentation implies that it is accurate and in sufficient detail and capable of being audited to allow for the verification of the hours spent rendering productive time, and non-productive time.

(iv) The FQHC or RHC may apply for an exemption to the minimum productivity standards requirement by submitting an exemption request to DHCS. The request must be supported with verifiable documentation demonstrating that the FQHC's or RHC's individual circumstance(s) that prevents the minimum productivity standards from being met. All exemption requests shall include the following documentation.

A. The specific reason(s) for the exemption and the number of times the specific reason(s) occurred that prevented the clinic from not being able to meet the minimum standards.

B. An explanation of why there is good cause to believe that the specific reason(s) listed in section (A) above will continue to exist in future years.

C. If the specific reason(s) for an exemption is related to lengthy visit times, the FQHC or RHC must submit verifiable documentation of the actual time spent seeing the patients at the time the visits occurred. The documentation submitted must be capable of being audited and be in sufficient detail to allow for the verification of the actual time spent.

D. If the specific reason(s) for an exemption is not related to time spent on actual visits, the clinic must submit documentation in sufficient detail so that DHCS may audit the occurrence of the specific reason(s) for the exemption and when the specific reason(s) occurred. The documentation submitted must verify the specific occurrence of permanent circumstances that negatively affect the utilization of a clinic.

E. the same documentation in A-D above is required for all fiscal year(s) subsequent to the rate setting fiscal year to determine if the clinical circumstances are still present, and still result in the inability to meet the minimum productivity standards. The subsequent year review is limited to all complete fiscal year(s), including any portion of a fiscal year that has occurred since the cost reporting year up to the time the audit occurs.

4. If a new facility does not respond within 30 days of DHCS' request for three comparable FQHCs or RHCs as described in subparagraph J.3(a) or the projected allowable costs as described in subparagraph J.3(b), DHCS will suspend processing of the new facility's request for reimbursement as an FQHC or RHC, until the required information has been provided.

5. The effective date for the rate of a new facility under **(1)** Section J**; (2) a new intermittent service site that is exempt from licensure that is established or affiliated with an FQHC; (3) a new mobile unit that is established or affiliated with an FQHC or RHC; or (4) an FQHC or RHC that relocates to a new site, is retroactive to the later of the date that the licensed FQHC or RHC was federally qualified as an FQHC or RHC, or the date the Department was notified of the new FQHC's or RHC's or intermittent clinic's or mobile unit's existence.**

   (a) In order for a new FQHC or RHC under section J.1 to receive a retroactive effective date to the date the licensed FQHC or RHC was first certified by the applicable federal agency, it must submit a complete Initial Rate Setting Application Package to the Department within 90 days from the date of the federal agency's written notification of approval as an FQHC or RHC. Otherwise, the effective date will be the date the Initial Rate Setting Application Package was received by the Department.

   (b) In order for an intermittent service site to receive the retroactive effective date to the date the intermittent service site was first qualified by the applicable federal agency as an FQHC site, it must notify the Department of the establishment of the intermittent service site's affiliation with an FQHC within 90 days from the date of the written notification of approval by the applicable federal agency as an FQHC site.

      (i) If the FQHC fails to meet the 90 day requirement or fails to obtain the applicable federal agency approval for the intermittent site, the effective date for the intermittent service site exempt from licensure, shall be the later of the date of the following:

         (1) The intermittent service site was first qualified by the applicable federal agency as an FQHC site, or

         (2) The date the FQHC notifies the Department that the intermittent service site was established

      (ii) RHCs, cannot have affiliated intermittent service sites.

   (c) If the mobile unit is an intermittent clinic exempt from licensure, see paragraph J.5.b. The PPS rate for all mobile units is set accordance with Section E.2.

      (i) In order for the licensed mobile unit to receive a retroactive effective date to the date the licensed mobile unit was first certified by the applicable federal agency as an affiliate of the FQHC or RHC, it must notify the Department of the establishment of the mobile unit's

affiliation with an FQHC or RHC within 90 days from the date of the federal agency's written notification of approval as an affiliate of the FQHC or RHC.

(ii) If the mobile unit fails to meet the 90 day requirement, or fails to obtain the applicable federal agency approval for the mobile unit, the effective date for the mobile unit shall be the later of the date of the following:

(1) The mobile unit was first certified by the applicable federal agency as an FQHC or RHC;

(2) The date the FQHC or RHC notified the Department that the mobile unit is an affiliate of an FQHC or RHC.

~~is retroactive to the later of the date that the licensed FQHC or RC was federally qualified as an FQHC or RHC, or the date a new FQHC or RHC at a new location was added to an existing FQHC or RHC as a licensed or enrolled Medi-Cal provider.~~

(d) In order for the FQHC or RHC to receive a retroactive effective date to the date that the licensed FQHC or RHC was first certified by the applicable federal agency as an FQHC or RHC at the relocated site, it must not have elected to treat the relocation as a change in scope of service under Section K; and it must submit a complete Initial Rate Setting Application Package to the Department within 90 days from the date of the federal agency's written notification of approval as an FQHC or RHC at the new location. If the FQHC or RHC does not submit a complete Initial Rate Setting Application within 90 days from the time the licensed FQHC or RHC was first certified by the applicable federal agency at the relocated site, or fails to receive the applicable federal agency approval for the relocated site, the effective date will be retroactive to the date of the applicable federal agency's approval only if the relocated site's per-visit rate is lower. Otherwise, the effective date will be the date the Initial Rate Setting Application Package was received by the Department. The per-visit rate at the relocated site must be set in accordance with Section J.

~~(a)~~ **(e)** An FQHC or RHC may continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number. Until its FQHC or RHC provider number is received, a facility must not bill the Medi-Cal program using the FQHC or RHC provider number of another facility. The preceding sentence will not apply to intermittent service sites that are affiliated with an FQHC or RHC and that operate less than ~~20~~**30** hours per week or in mobile facilities.

~~(b)~~ **(f)** DH**C**S will reconcile the difference between the fee-for-service payments and the FQHC's or RHC's PPS rate following notification to the provider that its FQHC or RHC number has been activated.

6. In order to establish comparable FQHCs or RHCs providing similar services, DHCS will require all FQHCs or RHCs to submit to DHCS either of the following:

(a) Its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report.

(b) A similar report utilizing a format as specified by DHCS applicable to the prior calendar year.

FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit a completed report in the format used in the prior calendar year. A new FQHC or RHC that has not previously submitted an annual utilization report will submit an annual utilization report or similar report as specified by DHCS.

K. Scope-of-Service Rate Adjustments

An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope-of-services provided by the FQHC or RHC, subject to all of the following:

1. A change in costs, in and of itself, will not be considered a scope-of- service change unless all of the following apply:

   (a) The increase or decrease in cost is attributable to an increase or decrease in the scope of the services defined in paragraph C.1.

   A scope of service change occurs when there is an increase or decrease in the costs attributable to an increase or decrease in the scope of services defined in paragraph C.1 when compared in the aggregate.

   A decrease in cost attributable to a decrease in the scope of services defined in paragraph C.1 is met only if the requirements of paragraph K.4 are met.

   (b) The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.

   (c) The change in the scope-of-services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

   (i) A change in "type, intensity, duration and amount of services" as it relates to K.2(a), K.2(b), K.2 (d) - K.2(g), and K.2(i) is:

   A. The addition of a new service, defined in paragraph C.1, that was performed by adding new professional staff who is licensed to perform the new service that no current professional staff is licensed to perform;

   B. The deletion of an entire service, defined in paragraph C.1, that the FQHC or RHC currently performs

(ii) The following are not considered a change in "type, intensity, duration, or amount of services":

A. A change in ownership;

B. The addition or reduction of staff members to or from an existing service;

C. A change in office hours; and

D. An increase in the number of encounters, in and of itself, does not constitute a change in the type, intensity, duration, or amount of services.

(d) The FQHC or RHC must implement the change in scope of service continuously for a full fiscal year (12 months) before it can submit a change in scope of service request.

(i) The increase or decrease in cost required by paragraph K.1.(a) shall be determined by comparing the full twelve (12) month fiscal year when the change occurred to the immediate, preceding full fiscal year without the change. The FQHC or RHC must submit supporting documentation showing the financial activity for the full 12 months of the fiscal year the change occurred and the immediately preceding fiscal year.

~~(d)~~
(e) The net change in the FQHC's or RHC's per-visit rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs or RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold will be applied to the average per- visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases ~~for a particular fiscal year~~ **the first full fiscal year (12 months) when the change occurred compared to the immediately preceding year.**

2. Rate changes based on a change in the scope-of-services provided by an FQHC or RHC will be evaluated in accordance with Medicare reasonable cost principles, as set forth in 42 CFR Part 413, or its successor. **All change in scope-of-service changes must comply with the productivity standards referenced in Section J.** Subject

to the conditions set forth in subparagraphs (a) through ~~(d)~~ **(e)**, inclusive of paragraph (1), a change in scope-of-service means any of the following:

(a) The addition of a new FQHC or RHC service (such as adding dental services, another health professional service, or other Medi- Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is not included in the existing prospective payment system reimbursement rate, or the deletion of an FQHC or RHC service (such as deleting dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is included in the existing prospective payment system reimbursement rate.

(b) A change in service described in paragraph C.1 due to amended regulatory requirements or rules.

(c) A change in service described in paragraph C.1 resulting from either remodeling an FQHC or RHC, or relocating an FQHC or RHC if it has not elected to be treated as a newly qualified clinic under Section F.

(d) A change in types of services described in paragraph C.1 due to a change in applicable technology and medical practice utilized by the center or clinic. **Once the cost of any electronic medical records and electronic dental records are included in an FQHC's or RHC's per-visit rate, the FQHC or RHC may not apply for an adjustment to its per-visit rate solely due to a subsequent acquisition and implementation of any electronic medical and dental records.**

A second change in scope for the addition of an electronic dental records system, after the FQHC or RHC had a change in scope for the addition of an electronic medical records system, must be because the electronic dental records system is a separate and distinct system from the electronic medical records system.

(e) An increase in the intensity of a service described in paragraph C.1 attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(f) Changes in any of the services described in paragraph C.1, or in the provider mix of an FQHC or RHC or one of its sites.

(g) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in paragraph C.1, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(h) Costs incurred by an FQHC or RHC for indirect medical education adjustments and any direct graduate medical education payment necessary for providing teaching services to interns and residents

at the FQHC or RHC that are associated with a modification of the scope of any of the services described in paragraph C.1.

(i) A change in the scope of a project approved by HRSA where the change impacts a covered service described in paragraph C.1.

3. An FQHC or RHC may submit a request for scope-of-service changes once per fiscal year, within 150 days of the beginning of the FQHC's or RHC's fiscal year following the year in which the change occurred. **Before the FQHC or RHC can submit a request for a scope-of-service change, the change in the scope of service must have already been in place for a full fiscal year (12 months).** Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's **first full** fiscal year in which the ~~request is~~ change occurred ~~submitted~~.

4. An FQHC or RHC must submit a scope-of-service rate change request within 150 days of the beginning of any FQHC's or RHC's fiscal year occurring after the effective date of this Section K if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope-of-services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If any FQHC or RHC discontinues providing onsite pharmacy or dental services, it must submit a scope-of-service rate change request within 150 days of the beginning of the fiscal year following the year in which the change occurred. As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent. **The determination of whether a 2.5% decrease exists must be a comparison of the per-visit rate during the full fiscal year (12 months) before the service was decreased to the per-visit rate in the immediately succeeding full fiscal year (12 months) after the decrease occurred.**

(a) A decrease in the scope of service occurs when any activity, function and space, included in the FQHC's or RHC's per-visit rate is deleted, eliminated or converted to an activity that is not conducted by the FQHC or RHC or FQHC or RHC staff.

5. If an FQHC or RHC wishes to bill dental hygienist services as separate visits, it must submit a change in scope-of-service that includes and documents a full fiscal year (12 months) of dental hygienist costs and visits.

6. Effective January 1, 2018, if an FQHC or RHC wishes to bill marriage and family therapist (MFT) services as separate visits, it must submit a change in scope-of-service that includes and documents a full fiscal year (12 months) of MFT costs and visits.

~~5.~~

7. Notwithstanding paragraph K.4, if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of- service change, the adjusted reimbursement rate for that scope-of-service change will be made retroactive to the date the scope-

of-service change was initially implemented. Scope-of-service changes under this paragraph must be submitted within 150 days after the adoption and issuance of the written instructions by DHCS.

~~6.~~

8. The reimbursement rate for scope-of-service changes implemented within the FQHC's or RHC's fiscal year ending in calendar year 2004 and subsequent fiscal years will be calculated as follows:

(a) If DHCS determines that documentation submitted by the FQHC or RHC accurately reflects the cost per-visit rate calculation for that particular year, DHCS will subtract the current PPS per-visit rate from the newly calculated per-visit rate for that particular year. The "current PPS per-visit rate" means the PPS per-visit rate in effect on the last day of the reporting period during which the scope-of-service change occurred.

(b) The difference computed as in 8~~6~~(a), between the newly calculated cost per-visit rate and the current PPS per-visit rate, is then multiplied by an 80 percent adjustment factor to arrive at an amount that is to be considered applicable to a scope-of-service adjustment for that year.

(c) That 80 percent adjustment amount is then added to the current PPS rate and the newly established rate becomes the newly adjusted PPS reimbursement rate, effective the first day following the fiscal year end that the FQHC or RHC submitted the documentation for the scope-of-service change. For example, an FQHC or RHC has a:

(i) Newly established per-visit rate of $115.00,

(ii) Current PPS per-visit rate of $95.00,

(iii) July l, 2003, to June 30, 2004, fiscal year and a

(iv) Scope-of-service change date of February 15, ~~2004~~ 2003.

The newly established PPS rate is calculated and effective as follows:

(v) $20.00 is the difference between the newly established per- visit rate ($115.00) and the current PPS rate ($95.00),

(vi) $16.00 is the 80 percent adjustment amount ($20.00 X 80 percent),

(vii) $111.00 is the newly established PPS rate ($95.00 + $16.00),

(viii) July l, 2004, is the date the $111.00 rate becomes effective.

(ix) The MEI will be applied to the PPS rate established in calendar year 2004 and subsequent fiscal years on the first day of October that is not within the particular FQHC's or RHC's fiscal year. For any FQHC or RHC that has a July l, 2003, to June 30, 2004, fiscal year (as described in the example above), October l, 2004, is the date of the MEI, which will be applied to the July 1, 2004, established PPS rate. For any FQHC or RHC that has a January 1, 2004 to December 31, 2004, fiscal year, October 1, 2005, is the

the particular FQHC's or RHC's 2003 fiscal year. For any FQHC or RHC that has a July 1, 2002, to June 30, 2003, fiscal year (as described in the example above), October 1, 2003, is the date of the MEI, which will be applied to the July 1, 2002, to September 30, 2003, established PPS rate. For any FQHC or RHC that has a January 1, 2003, to December 31, 2003, fiscal year, October 1, 2004, is the date the MEI will be applied to the January 1, 2003, established PPS rate.

~~7.~~

9. A written request under Section K must be made to DH**C**S and include differences in costs and visits, if applicable, associated with scope-of-service change(s), utilizing a cost report format as specified by DH**C**S. Costs must not be reported twice for duplicate reimbursement. Costs arising from extraordinary circumstances and for which the FQHC or RHC has either been reimbursed or for which supplemental reimbursement is pending under Section G will not be reimbursable as a scope-of-service rate change under either Sections F or K.

~~8.~~

10. Rate adjustments for scope-of-service changes under this Section K for an FQHC's or RHC's fiscal year ending in 2004, were deemed to have been filed in a timely manner so long as they were filed within 90 days following the end of the 150 day timeframe applicable to retroactive scope-of-service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year or the date the scope-of-service forms are received, whichever is later.

L. Administration of Managed Care Contracts

1. Where an FQHC or RHC furnishes services pursuant to a contract with a managed care entity (MCE) (as defined in Section 1932(a)(l)(B) of the Act), DH**C**S will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

2. Supplemental payments made pursuant to paragraph L.1 will be governed by the provisions of subparagraph (a) through (d), below.

   (a) FQHCs and RHCs that provide services under a contract with a MCE will receive, at least quarterly, state supplemental payments for such services that are an estimate of the difference between the payments the FQHC or RHC receives from MCEs and the payments the FQHC or RHC would have received under the methodology described in Section D, E, or J, and, if applicable, Section F.

(b) At the end of each FQHC's or RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's or RHC's contract with MCEs would have yielded under the methodology described in Section D, E, or J, and, if applicable, Section G.

(c) If the amount calculated wider the methodology described in Section D, E, or J, and, if applicable, Section G exceeds the total amount of supplemental and MCE payments, the FQHC or RHC will be paid the difference between the Section D, E, or J, and, if applicable, Section G amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC.

(d) If the amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G is less than the total amount of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G (based on actual visits) and the total amount of supplemental and MCE payments received by the FQHC or RHC.

3. Payments made to any FQHC or RHC for FQHC or RHC services under managed care contracts, as described in paragraphs l and 2 of this Section L, will exclude any financial incentive payments to the FQHC or RHC that are required by federal law to be excluded from the calculation described in paragraph L.2.

M. Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Prevention (CHDP) Program Coverage

l. Where a recipient has coverage under the Medicare or the CHDP program, DH**C**S will supplement the payment from those programs not to exceed the prospective payment reimbursement rates established under this Amendment.

2. Where an FQHC or RHC services are partially reimbursed by a third party such as CHDP, DH**C**S will reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate. Such reimbursement may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

No scope-of-service change request for dental hygienist services or dental hygienist in alternative practice services will be considered for an FQHC or RHC that elects the APM reimbursement rate pursuant to this paragraph N.2 (a).

(a) If an FQHC or RHC did not provide the services of a dental hygienist or dental hygienist in alternative practice before January 1, 2008, and later adds these services, a scope-of-service change ~~may~~ **must** be requested as provided in Section K. After a scope-of-service change to add the additional service has been **approved** ~~calculated and the PPS reimbursement rate has been revised to include the new service~~, an FQHC or RHC may elect the option to have dental hygienist services or dental hygienist in alternative practice services be reimbursed as a billable visit under the APM described in this Section N.

(b) For purposes of this Section N, "in the aggregate" when referenced with respect to the APM, is defined as the total revenue a facility would receive, calculated by multiplying the applicable reimbursement rate by the total number of services provided by dental hygienist or dental hygienist in alternative practice services in a given year and adding that revenue to the PPS reimbursement rate multiplied by the total number of services provided in given year that are compensated using the PPS reimbursement rate.

(c) For purposes of this Section N, "in the aggregate" when referenced with respect to the reimbursement rate under Section D, E, F, I, J, or K is defined as the total reimbursement which an FQHC or RHC would have been received using a PPS reimbursement rate (which does not include the services of a dental hygienist or dental hygienist in alternative practice as separate, billable visits) multiplied by the total number of services provided in a given year that are compensated using the PPS reimbursement rate.

(d) If the estimated total aggregate revenue for an FQHC or RHC under paragraph (d) above is greater than what the FQHC or RHC received in accordance with paragraph (c) above, DHCS will reimburse an FQHC or RHC for the difference between the amount it received in accordance with paragraph (c) above and the amount it would have received in accordance with paragraph (d) above. This process applies to the circumstance described in the first paragraph of paragraph N.2 (a).

P. Scope-of-Service Rate Adjustments for Marriage and Family Therapist

AN FQHC or RHC shall apply for a change in the scope of services request pursuant to Section K. for the addition of services provided by Marriage and Family Therapists (MFTs) at an FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

Requests by FQHCs or RHCs for scope-of-service changes shall be submitted once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's one full fiscal year in which the request is submitted.

In order for an FQHC or RHC to bill MFT services as a separately reimbursable PPS visit, a mandatory change of scope of services request must be submitted after MFT services have been provided by the FQHC or RHC for one full fiscal year.

Q. FQHC and RHC Services Provided Offsite (Outside the Four Walls of the Facility)

FQHC or RHC services rendered outside the four walls of an FQHC's or RHC's established place of business must adhere to all the requirements contained in this chapter. The FQHC's or RHC's established place of business is the business address, as determined by the applicable licensing entity.

1. Locations that are outside the four walls of the business address of an FQHC or RHC.
2. Inpatient services
3. Dental services rendered to FQHC patients by a private dental provider
4. Telehealth services
5. Store and Forward Telehealth Services
6. Mobile units and intermittent clinics
7. Homeless services

1. Locations That are Outside the Four Walls of the Business Address of an FQHC or RHC

An FQHC or RHC cannot be reimbursed at the PPS rate for FQHC or RHC outpatient services rendered at a location outside the four walls of the FQHC or RHC; unless, all of the following requirements are met:

(a) For RHCs, services rendered at an established patient's residence is the only location outside the four walls of an RHC that can be reimbursed at the RHC's PPS rate. An established patient's residence would include a Part A stay in a skilled nursing facility.

(b) All services provided outside of the four walls of the FQHC or RHC must be as defined in paragraph C.1.

(c) The services provided outside the four walls of the FQHC or RHC must be

(d) rendered by a physician, nurse practitioner, physician assistant, certified nurse midwife, licensed clinical social worker, clinical psychologist, or marriage family therapist employed or under contract with the FQHC or RHC at the time the services are furnished.

(e) The services provided outside the four walls of the FQHC or RHC must be provided to established FQHC or RHC patients in need of the professional services available at the FQHC or RHC site, but, due to the patient's medical condition, they are unable to travel to the FQHC or RHC. It is expected that the services provided in most cases are temporary and intermittent, and only when the existing patient is unable to travel to the clinic due to health reasons. If any one of the following conditions stated below are met, the patient is considered and "established patient" of the FQHC or RHC. See Paragraph Q.1.(f) for an exception for permanently homebound patients.

(i) An established patient is one who has an established medical record with the FQHC or RHC that was created during a visit within the four walls of the FQHC or RHC that met the requirements of paragraph C.1. The medical record must have been created within three years prior to date the FQHC or RHC services were rendered outside the four walls.

(ii) A patient that has been assigned to an FQHC or RHC by a managed care plan, and an FQHC or RHC physician and the managed care plan have entered into a Primary Care Physician (PCP) Agreement, is also considered an established patient of the FQHC or RHC.

(iii) See Paragraph Q.1.(f) for the requirements that must be met for a permanently homebound patient that has never been treated inside the FQHC or RHC and that is not assigned to the FQHC or RHC by a managed care plan, to be considered and established patient of the FQHC or RHC.

(f) A patient will not be considered unable to come to the clinic if the patient travels outside of their established residence to receive any services. When a patient is not considered unable to come to the FQHC or RHC, reimbursement at the PPS rate is not allowed.

(g) The treatment is a continuing treatment of an illness or injury for which an established patient has previously been treated for on the premises of the FQHC or RHC, unless the patient was permanently homebound from the inception that the FQHC or RHC services were rendered. A homebound patent is defined as one who is essentially confined to his home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except for periods of relatively short duration; e.g. for a walk prescribed as therapeutic exercise. In order for a permanently homebound patient that has never been treated inside the FQHC or RHC and that is not assigned to the FQHC or RHC by a managed care plan, to be considered an established patient of the FQHC or RHC, all the following requirements must be met:

(i) The patient cannot be enrolled in a managed care plan.

(ii) The homebound patient has ceased being treated by their primary

(iii) care physician within the prior three months from the date the FQHC or RHC services were rendered, and the homebound patient has elected to receive treatment from an FQHC or RHC physician.

(iv) The FQHC or RHC must furnish any services available inside the four walls of the FQHC or RHC to the permanently homebound patient, when needed. The FQHC or RHC must also furnish any services to the permanently homebound patient that the FQHC or RHC has agreements or arrangements with to furnish that are not available inside the four walls of the FQHC or RHC, when needed.

(v) A homeless patient is not considered permanently homebound.

(h) Services rendered outside the four walls of the FQHC or RHC must be based on a written individualized treatment plan. The treatment plan must meet all the following requirements:

v. The primary care physician's medical orders stating the specific services to be rendered, which is reviewed monthly by the ordering physician, if applicable.

vi. The actual services rendered on each visit and the rendering clinician.

vii. The patient's specific clinical prognosis and specific diagnosis each time the services are rendered.

viii. The clinical diagnosis that prevents the patient from coming to the clinic or that permanently renders the patient homebound, if applicable.

ix. The length of time the patient is expected to be unable to come to the clinic.

x. The patient's primary care physician must document his/her approval of any behavioral health services rendered.

(i) Although a Treatment Authorization Request (TAR) is not required, the FQHC or RHC must maintain the patient's medical records and document that the services rendered were medically necessary, similar to what is required to obtain an approved TAR.

(j) Any FQHC or RHC employee or contractor rendering services outside the four walls of the FQHC or RHC must be properly credentialed with the appropriate Medi-Cal managed care plans before they can render services outside the four walls of the FQHC or RHC and be reimbursed at the PPS rate.

(k) The FQHC or RHC must properly bill any managed care plan for the services rendered outside four walls of the FQHC or RHC, if applicable.

(l) The FQHC or RHC must maintain written policies that describe all the services that will be furnished outside the physical address of the established FQHC or RHC and when the services will be rendered. These policies must be approved by the Board of Directors. If there is no Board of Directors, the policies must be approved by at least the Owner, President, Medical Director and/or the Chief Executive Officer, if applicable. The above approval of the written policies is required before an FQHC or RHC is eligible to receive reimbursement at the PPS rate for services rendered outside the four walls of the FQHC or RHC.

(m) Any location outside the four walls of the FQHC that meets the definition of a site

(n) of service per Health Resources and Services Administration's (HRSA) Policy Information Notice (PIN) 2008-01 (or its successor), for health centers funded under section 330 of the Public Health Service (PHS) Act and FQHC Look-Alikes must be added to the FQHC's Scope of Project, Form 5 – Part B: Service Sites, prior to receiving reimbursement for services rendered at these locations. The FQHC must meet the HRSA's scope of project requirements for adding a new site for physical addresses that include a different suite, office, building, number, etc.

(o) For locations outside the four walls of the FQHC that are not required to be added to the FQHC's Scope of Project, Form 5 – Part B: Service Sites, the services and locations must be added to the Scope of Project, Form 5 – Part C: Other Activities, as required by the Health Resources and Services Administration's (HRSA) Policy Information Notice (PIN) 2008-01 (or its successor), for health centers funded under section 330 of the Public Health Service Act and FQHC Look-Alikes.

2. Inpatient Services

In order for an FQHC or RHC to receive reimbursement at the PPS rate for FQHC or RHC services rendered at a hospital, all of the following requirements are met:

(a) An employee or contractor of an FQHC or RHC must render the service.

(b) The service must be for the continuing treatment of an illness or injury for which an established patient of the FQHC or RHC has previously been treated for on the premises of the FQHC or RHC.

(c) The services must be provided to established FQHC or RHC patients in need of the professional services available at the FQHC or RHC, but, due to the patient's medical condition, they are unable to travel to the FQHC or RHC. It is expected that the services provided in most cases are temporary and intermittent, and only when the existing patient is unable to travel to the clinic due to health reasons. An "established patient" is one who has an established medical record with the FQHC or RHC that was created during a visit within the four walls of the FQHC or RHC that met the requirements of paragraph C.1. The medical record must have been created three years prior to date the FQHC or RHC services were rendered. A patient that has been assigned to an FQHC or RHC by a managed care plan and for which the FQHC or RHC and the managed care plan have entered into a Primary Care Physician (PCP) Agreement is also considered an established patient of the FQHC or RHC.

(d) If a mother meets the definition of an established patient of the FQHC or RHC, any newborn patient is presumed to meet the definition of an established patient.

(e) The person rendering the service must spend the majority of their time treating FQHC or RHC patients inside the four walls of the FQHC or RHC and occasionally go to the hospital for continuity of care.

3. Dental Services rendered to FQHC patients by a private dental provider

RHC's are ineligible to receive reimbursement at the PPS rate for any dental services rendered outside of the four walls of the RHC by a private dental provider. An FQHC may receive reimbursement at the PPS rate for any dental services rendered outside the four walls of the FQHC, provided that, all of the following requirements are met:

(a) The FQHC and the private dental provider must include in their contract a provision that the dentist's office cannot bill Medi-Cal directly for the same services that were billed at the PPS rate. If an FQHC chain organization includes multiple FQHCs that refer their patients to the same private dental provider, each FQHC must have a separate contract with the private dental provider. If an FQHC chain organization includes multiple FQHCs that refer their patients to the same private dental provider, the contract must include the specific service location that will refer patients to the private dental provider.

(b) All private dental providers must be properly licensed and credentialed with the applicable managed care plans.

(c) The dental services provided must be in accordance with The California State Plan, Limitations on Attachment 3.1A and Limitations on Attachment 3.1B, page 3E, and must be a Medi-Cal benefit pursuant to the Medi-Cal Dental Program Provider Handbook.

(d) Services must be rendered within the private dental provider's established place of business.

(e) The dental services must be included in the FQHC's Health Resources and Services Administration's (HRSA) Scope of Project Form 5 – Part A: Services Provided.

(f) The private dental provider's location must be added to the FQHC's Scope of Project, Form 5 – Part B: Service Sites per the Health Resources and Services Administration's (HRSA) Policy Information Notice (PIN) 2008-01 (or its successor), for health centers funded under section 330 of the Public Health Service (PHS) Act, prior to receiving reimbursement at the PPS rate.

(g) The patients seen at the private dental provider's location must be an established patients of the FQHC. The FQHC must refer its patients to the private dental provider, and document the date and the reason for the referral.

(h) An "established patient" is one who has an established medical record with the FQHC or RHC that was created during a visit within the four walls of the FQHC or RHC that met the requirements of paragraph C.1. The medical record must have been created three years prior to date the FQHC or RHC services were rendered. A patient that has been assigned to an FQHC or RHC by a managed care plan and for which the FQHC or RHC and the managed care plan have entered into a Primary Care Physician (PCP) Agreement is also considered an established patient of the FQHC or RHC.

(i) An established patient must also reside in the center's service area and be able to "reasonably" receive primary care services at the center.

(j) There are only two reasons an FQHC can refer a patient to a private dental provider and receive reimbursement at the PPS rate. First, the patient is in need of dental services and the FQHC does not provide the dental services at the FQHC; or second, the FQHC's dental services are at maximum capacity.

(k) The contractual relationship with the dentist cannot result in the FQHC becoming a billing agent for the private dental provider. This precludes the FQHC from billing the PPS rate for any patients who were receiving treatment at the dental practice prior to entering into a contractual relationship with the FQHC, even if the patient was also seen at the FQHC, prior to the contract. It also precludes the FQHC from contracting with private dental providers when they have the capabilities and capacity to render the services at the FQHC.

(l) If an FQHC organization has more than one FQHC location, the FQHC that can receive reimbursement at the PPS rate for the private dental services is the FQHC that referred the patient to the private dental provider.

(m) The FQHC must have written policies that explain when dental services will be referred to a private dental provider, which will include how the FQHC will determine when their dental services are at maximum capacity and a referral is needed. These policies must be approved by the Board of Directors. Approval of the written policies is required before an FQHC is eligible to receive reimbursement at the PPS rate for dental serviced referred to a private dental provider.

4. Telehealth Services

Telehealth services are the exchange of medical information from one site to another using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time (delays in seconds or minutes), interactive communication between the patient and physician or practitioner at the distant site to improve a patient's health. The telehealth communication system must allow the provider at a distant site to visualize directly the patient's condition without the interposition of a third person's judgment. This is not applicable for tele-ophthalmology, tele-dermatology, and tele-dentistry that is eligible to receive reimbursement at the PPS rate for Store and Forward services.

In-person contact between a health care provider and a patient is not required for services provided through telehealth. The type of setting where telehealth services are provided for the patient or by the health care provider is not limited. Telehealth services do not include telephone calls, emails, or facsimile transmissions. The following definitions are applicable to telehealth services:

Originating Site – Where the patient is located at the time health care services are provided via a telecommunications system, or where the asynchronous store and forward service originates.

Distant Site – Where the health care provider is located while providing services via a telecommunication system.

The services rendered at an originating site are not considered telehealth services and are reimbursed according to the requirements of Section C. AN FQHC or RHC cannot receive reimbursement at the PPS rate for telehealth services unless all of the following requirements are met:

(a) When the originating site and the distant site are FQHCs or RHCs that are part of the same organization, only the originating site may bill for the visit. Under no circumstances can two visits be billed.

(b) When the originating site is an FQHC or RHC, and the distant site is not an FQHC or RHC, the following requirements must be met before the services rendered at the distant site can be reimbursed at the PPS rate:

- **(i) The services furnished at the distant site are not furnished at the originating site.**
- **(ii) Only one visit can be reimbursed at the PPS rate regardless of the services rendered at the originating site.**
- **(iii) The FQHC or RHC must have an arrangement or agreement with the distant site to furnish the telehealth services.**
- **(iv) The originating site must compensate the distant site for the telehealth services furnished to its patients.**
- **(v) The distant site does not bill for the telehealth services outside the PPS rate.**

(c) When the originating site and the distant site are separate FQHCs or RHCs that are not part of the same organization, the following requirements must be met before the services rendered at the distant site can be reimbursed at the PPS rate:

- **(i) The services furnished at the distant site are not furnished at the originating site.**
- **(ii) The FQHC or RHC must have an arrangement or agreement with the distant site to furnish the telehealth services.**
- **(iii) The originating site does not compensate the distant site for the telehealth services rendered.**

(d) The health care provider at the originating site must first obtain verbal consent from the patient prior to providing service via telehealth and shall document verbal consent in the patient's medical record, including the following:

- **(i) A description of the risks, benefits and consequences of telehealth services.**
- **(ii) The patient retains the right to withdraw at any time**
- **(iii) All existing confidentiality protections apply**
- **(iv) A patient has access to all transmitted medical information**
- **(v) No dissemination of any patient information to other entities**

(vi) without further consent

(e) All telehealth services must be as defined in paragraph C.1.

(f) Although a Treatment Authorization Request (TAR) is not required, the FQHC or RHC must maintain the patient's medical records and document that the services rendered were medically necessary, similar to what is required to obtain an approved TAR.

(g) All medical information transmitted during the delivery of health care via telemedicine must become part of the patient's medical record and maintained by both the originating and distant sites.

(h) Telehealth services provided at a distant site must be performed by a licensed health care provider.

5. Store and Forward Telehealth Services

An interactive telecommunications system is not required for store and forward services rendered at an FQHC or RHC. Face-to-face contact between a health care provider and a patient for tele-ophthalmology, tele-dermatology, and tele-dentistry by store and forward are not required. For purposes of this section, "tele-ophthalmology, tele-dermatology, and tele-dentistry by store and forward" means an asynchronous transmission of medical or dental information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for tele-ophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, or a dentist, where the physician, optometrist, or dentist at the distant site reviews the medical or dental information without the patient being present in real time.

The following definitions are applicable to store and forward telehealth services:

Originating Site – Where the asynchronous store and forward service originates.

Distant Site – Where the health care provider is located while providing services after an asynchronous store and forward transmission is received.

An FQHC or RHC cannot receive reimbursement at the PPS rate for any tele-ophthalmology, tele-dermatology, and tele-dentistry store and forward services unless all of the following requirements are met:

(a) A patient receiving tele-ophthalmology, tele-dermatology, or tele-dentistry by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, optometrist, or dentist and shall receive an interactive communication with the distant specialist physician, optometrist, or dentist, upon request. If requested, communication with the distant specialist physician, optometrist, or dentist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation.

(b) The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a patient receives tele-ophthalmology and tele-dermatology by store and forward.

(c) Only one visit is eligible to be reimbursed at the PPS rate when an RHC or FQHC is a distant site, even if the services provided at the distant site are on a different day than the services rendered at the originating site. Regardless of the relationship between the originating site and distant site, only the originating site can bill one visit for the services. Under no circumstances can two visits be billed for store and forward telehealth services.

(d) an FQHCWhen the originating site and the distant site are FQHCs or RHCs that are part of the same organization, only one visit must be billed under the originating site only.

(e) The images must be specific to the patient's condition and adequate to support any subsequent treatment provided as a result of the physician's review of the image.

(f) Tele-ophthalmology and tele-dermatology by store and forward must be rendered by a physician who has completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or dermatology respectively.

6. Mobile Units and Intermittent Clinics

Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit.

(a) RHCs are prohibited from establishing intermittent service sites that are exempt from licensure and receiving reimbursement at the PPS rate.

(b) For an FQHC to establish an intermittent clinic site, the address of the intermittent clinic must be included on the establishing FQHC's license issued by the licensing entity.

(c) An FQHC that establishes or affiliates with an intermittent service site exempt from licensure and/or a mobile unit, must notify DHCS in accordance with all applicable state regulations and statutes of the separate intermittent clinic location and/or mobile unit, prior to receiving reimbursement at the PPS.

(d) When an FQHC chain organization has multiple FQHCs, the FQHC that affiliates with the intermittent service site, must be the FQHC that is in closest proximity to the intermittent service site.

(e) When an FQHC or RHC organization has multiple FQHCs or RHCs, the following circumstances must be used to determine the FQHC or RHC that established the mobile unit:

(i) The service area of the mobile unit
(ii) The scope of service of the mobile unit
(iii) Supervisory and administrative oversight of the mobile unit
(iv) The location where the mobile unit parks when not in service

(f) A licensed mobile unit does not have to meet the hours of service requirements as an intermittent clinic that is exempt from licensure.

(g) Any intermittent service site or mobile unit of an FQHC that meets the definition of a site of service per Health Resources and Services Administration's (HRSA) Policy Information Notice (PIN) 2008-01 (or its successor), for health centers funded under section 330 of the Public Health Service (PHS) Act or FQHC Look-Alikes, must be added to the FQHC's Scope of Project, Form 5 – Part B: Service Sites, prior to receiving reimbursement for services rendered at these locations.

7. Homeless Services

An FQHC or RHC cannot receive reimbursement at the PPS rate for any FQHC or RHC services rendered to homeless patients outside the physical address of the FQHC or RHC unless all of the following requirements are met:

(a) Reimbursement at the PPS rate for services rendered to the homeless is only eligible for established patients of the FQHC or RHC.

(b) If any one of the following conditions stated below are met, the homeless patient is considered an "established patient" of the FQHC or RHC.

(i) An established patient is one who has an established medical record with the FQHC or RHC that was created during a visit within the four walls of the FQHC or RHC that met the requirements of paragraph C.1. The medical record must have been created within three years prior to date the FQHC or RHC services were rendered outside the four walls.
(ii) A patient that has been assigned to an FQHC or RHC by a managed care plan, and an FQHC or RHC physician and the managed care plan have entered into a Primary Care Physician (PCP) Agreement, is also considered an established patient of the FQHC or RHC.

(c) An established patient is one who has an established medical record that was generated during the provision of FQHC or RHC services that occurred within the four walls of the FQHC or RHC and met the requirements of paragraph C.1., within the prior three years from the date the FQHC or RHC services were rendered outside the four walls.

(d) A patient that has been assigned to an FQHC or RHC by a managed care plan, and for which the FQHC or RHC and the managed care plan have entered into a

(e) Primary Care Physician (PCP) Agreement, is considered an established patient of the FQHC or RHC.

(f) All services provided to the homeless must be as defined in paragraph C.1.

(g) The services provided to the homeless must be rendered by a physician, nurse practitioner, physician assistant, licensed clinical social worker, clinical psychologist, or marriage family therapist employed or under contract with the RHC or FQHC at the time the services are furnished.

(h) Only medically necessary services provided to the homeless are covered. All services must be rendered in accordance with a written individualized treatment plan that is developed to treat specific injuries or illnesses. The treatment plan must meet all the following requirements and include:

(i) The primary care physician's medical orders stating the specific services to be rendered.
(ii) The actual services rendered each visit and the rendering clinician.
(iii) The patient's specific clinical prognosis and specific diagnosis each time the services are rendered.
(iv) The patient's primary care physician must document his/her approval of any behavioral health services rendered to the homeless.

(i) Although a Treatment Authorization Request (TAR) is not required, the FQHC or RHC must maintain the patient's medical records and document that the services rendered were medically necessary, similar to what is required to obtain an approved TAR.

(j) Any FQHC or RHC employee or contractor rendering services to the homeless must be properly credentialed with the appropriate Medi-Cal managed care plans before the services will be reimbursed at the PPS rate.

(k) The FQHC or RHC must properly bill any managed care plan for the services rendered to the homeless.

(l) The FQHC or RHC must maintain written policies that describe all the services that will be furnished to the homeless. These policies must be approved by the Board of Directors. If there is no Board of Directors, the policies must be approved by at least the Owner, President, Medical Director and/or the Chief Executive Officer, if applicable. The above approval of the written policies is required before an FQHC or RHC is eligible to receive reimbursement at the PPS rate for services rendered outside the four walls of the FQHC or RHC.

(m) Locations where homeless patients are treated, that are not required to be added to the FQHC's Scope of Project, Form 5 – Part B: Service Sites, must be added to the Scope of Project, Form 5 – Part C: Other Activities, as required by the Health Resources and Services Administration's (HRSA) Policy Information Notice (PIN) 2008-01 (or its successor), for health centers funded under section 330 of the Public Health Service Act or FQHC Look-Alikes.