Special Clinics: Federally Qualified Health Centers (FQHC)

Program Overview

Federally Qualified Health Centers (FQHCs) are defined by the Health Resources and Services Administration (HRSA) as health centers providing comprehensive primary and preventive healthcare to medically underserved and vulnerable populations. Additional health services are provided as appropriate and necessary.

FQHCs are under an encounter reimbursement methodology for approved services provided by FQHC qualified health professionals.

Federal Medicaid regulations allow State Medicaid Agencies to pay FQHCs providing services under a contract with a Medicaid Managed Care Organization (MCO; also known as a Managed Care Entity [MCE]) supplemental payments for furnishing such services. This concept is referred to as the WRAP Supplemental Payment Program. MCOs are required to follow Nevada Medicaid's State Plan and Medicaid Service Manual (MSM) guidelines.

Policy

Please see the appropriate MSM Chapters for covered and non-covered Medicaid Services not identified in MSM 2900. The Medicaid Services Manual (MSM) is on the DHCFP website at http://dhcfp.nv.gov.

- MSM Chapter 100 – Medicaid Program: contains important information applicable to all provider types
- MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services
- MSM Chapter 600 – Physician Services
- MSM Chapter 1000 – Dental
- MSM Chapter 1200 – Prescribed Drugs (for in-house Pharmacy refer to Provider Type 28 Billing Guide)
- MSM Chapter 2900 – FQHCs
- MSM Chapter 3400 – Telehealth Services

Covered Services

Encounters: A "visit" or an "encounter" for the purposes of reimbursing FQHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient for the same service type. An FQHC may be reimbursed for up to three service specific visits per patient per day provided that the FQHC has separate established rates for each encounter type.

Fee For Service (FFS)

- MEDICAL services under Fee-for-Service (FFS), invoice using the following:
    - G0466 (New Patient Medical Visit)
    - G0467 (Established Patient Medical Visit)
    - G0468 (Annual Well Visit and/or Initial Preventive Physical Exam)
- BEHAVIORAL HEALTH services under Fee-for-Service (FFS), invoice using the following:
    - G0469 (New Patient Mental Health Visit)
    - G0470 (Established Patient Mental Health Visit)
- DENTAL services under FFS, invoice using 41899 (Unlisted procedure, dentoalveolar structures).
- SCHOOL BASED FQHCs, under FFS, invoice using T1015 (Clinic visit/encounter, all-inclusive).

Managed Care

- MEDICAL services under Managed Care, invoice using Current Procedural Terminology (CPT) codes.

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Up to two times per calendar year the FQHC may bill for additional reimbursement for Family Planning Education when it is provided and documented in the patient's record, along with the encounter rate. Use CPT code 99401 (Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual).

- BEHAVIORAL HEALTH services under Managed Care, invoice using CPT codes.
- DENTAL services under Managed Care, invoice using CPT codes.

FQHC Telehealth Services

A licensed professional operating within the scope of their practice under state law may provide services via telehealth. Providers must follow guidelines set forth in MSM Chapter 3400 (Telehealth Services).

- **Originating Site:** The FQHC may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services (i.e. consult with specialist). If the originating site and distant site are two different encounter sites, the originating site may only bill the telehealth facility fee (Q3014), and the distant encounter site may bill the encounter code.
- **Distant Site:** FQHCs providing services for a recipient from a distant site may bill the appropriate encounter rate with Place of Service (POS) Code 02. Use of the POS code certifies the service meets telehealth requirements.

Long-Acting Reversible Contraception (LARC)

FQHCs are reimbursed for LARC services in addition to a qualified Medical Encounter:

- The insertion and removal of LARC devices are invoiced using the following codes:
  - 58300 (Insertion of IUD)
  - 58301 (Removal of IUD)
  - 11981 (Insertion of a drug delivery implant)
  - 11982 (Removal, non-biodegradable drug delivery implant)
  - 11983 (Removal and reinsertion of a non-biodegradable drug delivery implant)

  Procedure codes 58300, 58301, and 11982 have a service limit of 2 units allowed per day. Procedure codes 11981 and 11983 have a service limit of 2 units allowed per 3 rolling years.

- LARC devices are invoiced using the following codes; claims for these codes must include the associated National Drug Code (NDC):
  - J7296 (Kyleena, 19.5 MG – IUD)
  - J7297 (Liletta, 52 MG – IUD)
  - J7298 (Mirena, 52 MG – IUD)
  - J7300 (Intrauterine Copper Contraceptive)
  - J7301 (Skyla, 13.5 MG – IUD)
  - J7307 (Etonogestrel Implant System)

FFS *billing for LARCs codes shall be placed on separate claim lines from the Medical encounter.*

Managed Care *billing for LARCs shall be submitted according to the WRAP Supplemental Payment Program.*

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Non-Covered Services

FQHC ancillary services: Non-encounter services that are covered by Nevada Medicaid and provided by an appropriate Medicaid enrolled provider may be reimbursed outside of the encounter. MSM Chapter 2900:

- Ancillary services may be reimbursed on the same date of service as an encounter by a qualified Medicaid provider.
- The FQHC must enroll within the appropriate provider type and meet all MSM coverage guidelines for the specific ancillary service.
- Ancillary services billed outside of an encounter must follow prior authorization policy guidelines for the specific service provided.

WRAP Supplemental Payment Reimbursement

To submit for WRAP Supplemental Payment, information can be found on the DHCFP website. The links for specific information (i.e., WRAP Reference Guide; WRAP Training; Sample WRAP Submission File) are located at:

http://dhcfp.nv.gov/Pgms/CPT/FederallyQualifiedHealthCenters/FQHC/
Under "Links" on the right of the page.

http://dhcfp.nv.gov/Resources/Rates/RAPWRAP/
Under "Resources" on right of the page:

- Valid Encounter CPT list (questions on validity of specific CPT codes should be directed by email to the DHCFP staff, under "Contacts" on the WRAP webpage)

Prior Authorization (PA) Requirements

For Specialty 181 (FQHC), no PAs are required for eligible encounters. Please refer to MSM Chapter 2900 for policy limitations.

LARC codes 11981 and 11983 require PA to exceed the service limitation.

Billing Instructions

Providers must submit claims to Nevada Medicaid. Claims must comply with the instructions in the 837P Companion Guide for electronic transactions located on the Electronic Claims/EDI webpage.

For all dental services billed using American Dental Association (ADA) "D" codes, submit the 837D electronic transaction.