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 reimbursements are calculated using an encounter methodology for approved services provided by FQHC qualified health professionals. Managed Care Organizations (MCO) are required to follow Nevada Medicaid's State Plan and Medicaid Service Manual (MSM) policy and billing guidelines.

For FQHC Providers Rendering Dental Services Only, Effective January 1, 2026 - Federal Medicaid regulations allow State Medicaid Agencies to disperse certain supplemental payments when FQHC providers are rendering services under a contract with a Medicaid Managed Care Organization (MCO), also known as a Managed Care Entity (MCE) or Dental Benefits Administrator (DBA). These payments, when applicable, are a calculation of the difference between the payments the FQHC receives from the MCE(s) for all qualified Medicaid visits and the payments the FQHC would have received for fee-for-service (FFS) Medicaid recipients receiving the same services. This concept is referred to as the WRAP Supplemental Payment Program, additional information is detailed below.

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 Nevada Medicaid 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

An FQHC visit/encounter is a medically necessary, face-to-face contact with one or more qualified health professionals that takes place on the same day with the same patient for the same service type; a visit/encounter can also take place with the same qualified health professional for multiple contacts with the same patient on the same day. Only one (1) qualified medical, behavioral health, and/or dental service type visit/encounter is billable per patient per day. An FQHC may be reimbursed for up to three different service type visits per patient per day as long as the FQHC has separate established rates for each service type visit/encounter, which are Medical, Behavioral Health, and Dental.

Fee For Service (FFS)

An FFS Medical and/or Behavioral Health visit/encounter is identified by billing one unit of the valid encounter code listed below. In order to identify the nature of the services rendered, the FQHC must also submit separate claim lines to identify each appropriate Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) code rendered, known as Shadow Billing. Valid codes for shadow billing can be found on the Nevada Medicaid FQHC webpage.

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- 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

A Managed Care Medical and/or Behavioral Health visit/encounter is identified by the valid encounter code listed below and at least one valid code from the Shadow Billing Code List that is associated with the service type. The Shadow Billing Code List is found on the Nevada Medicaid FQHC webpage.

- MEDICAL services under Managed Care 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 Managed Care invoice using the following:
    - G0469 (New Patient Mental Health Visit)
    - G0470 (Established Patient Mental Health Visit)
- DENTAL services under Managed Care, invoice using CPT codes.

FQHC Telehealth Services

Telehealth is the use of a telecommunications system instead of an in-person recipient encounter for professional consultations, office visits, office psychiatry services and a limited number of other medical services. Telehealth may be used by any Nevada Medicaid and Nevada Check Up provider working within their scope of practice to provide services that can be appropriately provided via telehealth. Please review Medicaid Services Manual (MSM) Chapter 3400 (Telehealth Services) for complete policy, covered services, non-covered services and coverage requirements.

The telecommunications system used must be appropriate for the service being provided. Facsimile machines, electronic mail, and text messages do not meet this criteria.

Distant Site

The distant site is the site where the provider delivering services is located at the time the service is provided via a telecommunications system. The provider at the distant site must use the appropriate Place of Service (POS) code in addition to the appropriate modifier when billing for services provided via telehealth. Note that for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims and billed by outpatient providers on institutional claims, the GT modifier (telehealth service rendered via interactive audio and video telecommunications system) is required.

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Note: The distant site may not also be the originating site. Providers may not bill for both the service being rendered and the telecommunication system used by the recipient.

Originating Site

The originating site is the location where an eligible Medicaid/Nevada Check Up recipient is at the time the service, if the telecommunications system used to receive services is provided by a Nevada Medicaid provider.. FQHC providers billing encounter rates may bill an encounter rate in lieu of the originating site fee. Per diem or encounter-based providers would not bill HCPCS code Q3014 and an encounter code, as the facility fee is already included in the per diem/encounter rates. **If the recipient is not utilizing a facility's telecommunication system, or the telecommunication system used is a recipient's smart phone or home computer, the facility fee may not be billed.**

Telehealth Billing Requirements

Place of Service Codes	Description
02	Telehealth provided in a location other than in a recipient's home
10	Telehealth provided in a recipient's home

Modifiers	Description
93	Synchronous audio only
95	Synchronous telehealth service rendered via a real-time interactive audio and visual telecommunications system
G0	Telehealth service for diagnosis, evaluation or treatment of symptoms of an acute stroke
GQ	Telehealth service rendered via an asynchronous telecommunications system (store and forward)
GT	Interactive audio and video telecommunication systems (Institutional claims - Critical Access Hospital only)

Family Planning Codes Eligible for Separate Reimbursement Outside Encounter

Family Planning Counseling

FQHCs may bill CPT code 99401 with modifier FP to receive additional reimbursement for Family Planning Education, up to two times per calendar year with substantiating documentation in the patient's record.

Long-Acting Reversible Contraception (LARC)

FQHCs are reimbursed for LARC services in addition to a qualified medical encounter**.** Billing for LARC codes is listed on separate claim lines from the medical service type encounter code. Providers are instructed to bill their usual and customary amounts for each code. *Note: codes billed at lesser amounts will pay at the lesser amount.* Modifier 25 **must be included** on the medical encounter code when billed in conjunction with a non-PAD LARC code.

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- The insertion and removal of LARC devices are invoiced using the following non-Physician Administered Drug (PAD) 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 two (2) units allowed per day. Procedure codes 11981 and 11983 have a service limit of two (2) units allowed per three (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)

FQHC Ancillary Services

Non-encounter services that are covered by Nevada Medicaid and provided by another appropriate Medicaid enrolled provider type 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

Important Update: WRAP Applicable to Dental Claims Only Effective 1/1/2026

Effective January 1, 2026, the WRAP program will be discontinued for medical and behavioral health encounter codes billed for services rendered from that date forward. WRAP payments for dental encounter codes billed will continue for services rendered through January 1, **2027**. That is, beginning 1/1/2026, WRAP payments will continue to be paid only for the following:

- Services billed for dental, and
- Non-dental services rendered on or before December 31, 2025.

General information can be found on the WRAP Supplemental Payment Program webpage. The formula for calculating and distributing these payments is authorized pursuant to the Medicaid State Plan, Attachment 4.19 B, Pages 1 – 4.

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

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- http://dhcfp.nv.gov/Pgms/CPT/FederallyQualifiedHealthCenters/FQHC/
  Under "Links" on the right of the page.
- https://dhcfp.nv.gov/Pgms/SR/RAPWRAP/
  "Resources" on right of the page include valid the Encounter CPT/HCPCS list. Questions on validity of specific CPT/HCPCS codes should be directed by email to Nevada Medicaid staff, under "Contacts" on the same page.

Prior Authorization (PA) Requirements

For Specialty 181 (FQHC), no PAs are required for eligible encounters, with the exception of LARC codes 11981 and 11983 which require PA to exceed the service limitations. Please refer to MSM Chapter 2900 for other policy limitations.

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.