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.
- **For FQHC Providers Rendering Adult Dental Services, Effective July 1, 2026** – Expanded dental services will be covered for Medicaid-eligible adults age 21 and older, as described in Medicaid Services Manual Chapter 1000 and Provider Type 22 Billing Guide. Please note that these expanded benefits are subject to a $1,000 expenditure limit per calendar year.

  The $1,000 annual calendar year expenditure limit will be calculated using the Fee-for-Service (FFS) Fee Schedule for Provider Type 22 - Dentists, using the reimbursement rates for the individual CDT/CPT/HCPCS code services performed. Validation of calculations and related questions should be directed to Nevada Medicaid's fiscal agent.

  Services provided that exceed the annual $1,000 limit are non-covered benefits and the financial responsibility of the recipient when the written requirements of MSM 100, Section 105.3 C. are met. The weekly Remittance Advice will note the new error code 5751 ($1000 Allowed Per Calendar Year) for applicable claims as follows:

  - Pay (Partial Claim) – Audit 5751 will post for claim amounts paying up to the $1,000 maximum, leaving non-covered balances subject to recipient financial responsibility. Please note that non-covered "partial claim" balances are based on the FFS fee schedule reimbursement rate for the individual CDT/CPT/HCPCS code services performed.
  - Deny (Full Claim) – Audit 5751 will post for claims amounts when no remaining benefit is available. These are non-covered balances subject to recipient financial responsibility.

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 nevadamedicaid.nv.gov/resources/medicaid-services-manual/.

- 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

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- 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.

- 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.

Managed care organizations must not deny valid claims submitted by an FQHC, regardless of whether the FQHC is the recipient's designated primary care provider.

- 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)

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- 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 CDT codes.

The G-encounter code for shadow billing is required to be listed on the first claim line. Failure to list the encounter code on the first claim line may result in payment delays.

FQHC Telehealth Services

Reference the Telehealth Billing Instructions for further guidance.

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.

- 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)

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- 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. Per 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:

- nevadamedicaid.nv.gov/programs/federally-qualified-health-centers-fqhc/
- nevadamedicaid.nv.gov/programs/supplemental-reimbursment/wrap-supplemental-payment-program/

  Review the "Resources" section for the Valid 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

For Medical and Behavioral Health encounters, providers must submit claims appropriately to Nevada Medicaid or MCOs, as WRAP payments have been discontinued as of 1/1/2026.

For all dental services billed using American Dental Association (ADA) "D" codes, submit the 837D electronic transaction. Claims must comply with the instructions in the Companion Guide for electronic transactions located on the Electronic Claims/EDI webpage.