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16 Federally Qualified Health Centers (FQHC)

A Federally Qualified Health Center (FQHC) is a health care center that meets one of the following requirements:

- Receives a grant under Section 329, 330, 340, or 340A of the Public Health Services Act
- Meets the requirements for receiving such a grant as determined by the Secretary based on the recommendations of the Health Resources and Services Administration within the Public Health Service
- Qualifies through waivers of the requirements described above as determined by the secretary for good cause
- Functions as outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act

The policy provisions for FQHC providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 48.

16.1 Enrollment

Medicaid's Fiscal Agent enrolls FQHC providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a FQHC provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for FQHC-related claims.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

NOTE:

The 10-digit NPI is required when filing a claim.

FQHC facilities are assigned a provider type of 56 (FQHC) and the valid specialty is 080 (Federally Qualified Health Center). Registered nurses should bill using the clinic number as the rendering NPI (Block 24J) on the CMS-1500 claim form.

Physicians, Nurse Midwives, Certified Registered Nurse Practitioners, and Physician Assistants affiliated with the FQHC are issued individual NPIs that are linked to the FQHC number. Each of these providers is assigned a provider type of 56 (FQHC). Valid specialties are as follows:

- All valid specialties associated with physicians (refer to Chapter 28 Physician)
- 095 (Certified Nurse Midwife)
- 093 (Certified Registered Nurse Practitioner)
- 100 (Physician Assistant)

Enrollment Policy for FQHC Providers

To participate in the Alabama Medicaid Program, FQHC providers must meet the following requirements:

- Submit appropriate documentation from the Department of Health Resources and Services, Public Health Services (PHS), that the center meets FQHC requirements as evidenced by a copy of a grant awards letter
- Submit a budgeted cost report for its initial cost reporting period
- Federally Funded Health Centers, which are Medicare certified, must also submit copies of Medicare certification
- Comply with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) for all laboratory-testing sites

Provider contracts are valid for the time of the grant award period, and are renewed yearly in accordance with the grant renewal by PHS. A copy of the grant renewal by PHS must be forwarded to Medicaid as verification of continuing FQHC status. They are renewed upon receipt of proof that requirements stated in the *Alabama Medicaid Agency Administrative Code* Rule No. 560-X-48-01 have been met.

The effective date of enrollment will be the first day of the month in which the Medicaid enrollment application was received and the termination date will be 60 days beyond the end date of the budget period on the Grant Award Notice.

FQHCs approved for enrollment will be issued a provider agreement for the services for which they agree to provide. This agreement must be signed and returned to Medicaid within 30 days of the date mailed to the provider. Names of satellite center(s) are indicated in the provider agreement.

NOTE:

FQHC's wishing to enroll a Mobile Dental Clinic, you do not have to enroll the clinic with Medicaid. You will need to submit a request to Medicaid's fiscal agent. Provider Enrollment to add the mobile provider specialty (299) to your existing provider file along with a copy of your certification received from the Alabama Dental Board. **When filing claims for mobile dental services please indicate your place of service as 15.**

Complete guidelines for mobile dental clinics are in Provider Manual Chapter 13 (Dental).

NOTE:

Each satellite center must complete an enrollment application. Physicians, Nurse Practitioners, Nurse Midwives, and Physician Assistants associated with the clinic must also complete enrollment applications.

FQHCs are required to notify Medicaid's fiscal agent in writing within five state working days of any of the following changes:

- Losing FQHC status
- Any changes in dates in the FQHC grant budget period
- Opening(s) and/or closing(s) of any satellite center(s)
- Additions or terminations of providers

Patient 1st Requirements for Federally Qualified Health Centers (FQHC)

- Patient 1st is a program to create patient centered, quality focused care through a medical home by linking Medicaid recipients with a primary medical provider (PMP). The PMP coordinates care for recipients by providing and arranging for each recipients health care needs. **Refer to Chapter 39, Patient 1st, for details and requirements about the Patient 1st Program.**

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency.

16.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

NOTE:

FQHC physicians, Nurse Practitioners, Nurse Midwives, and Physician Assistants should refer to Chapter 28, Physician, for additional information.

NOTE:

Psychologists and Clinical Social Workers may provide services to QMB and EPSDT referred recipients. Please refer to Chapter 34 Psychologist, for additional information as listed under the **entire** Service Documentation section and the section that outlines Procedure Codes and Modifiers. The Psychologist and the CSW must operate within the scope of practice as established by their respective governing boards.

16.2.1 Benefits

Services provided by an FQHC include medically necessary diagnostic and therapeutic services and supplies provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, registered nurses, or clinical social worker; and services and supplies incidental to such services as would otherwise be covered if furnished by a physician. Any other ambulatory services offered by the center that are included in the State Plan are covered except for home health. Home Health services are excluded as an FQHC service because home health services are available on a state wide basis.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

16.2.2 Limitations

Home health services are excluded as an FQHC service because home health services are available on a statewide basis.

Reimbursement for other ambulatory services covered by the State Plan includes but is not limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21, family planning, prenatal, and dental for individuals under age 21. These services are subject to policies and routine benefit limitations for the respective program areas. These services do not count against the routine benefit limits for medical encounters.

FQHC clinic visits, outpatient, and inpatient services are subject to the same routine benefit limitations as physician visits. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

16.2.3 Reimbursement

FQHC services and other ambulatory services provided at the FQHC including satellite center(s) will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 56, for details.

Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state FQHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

NOTE:

Since FQHC providers are reimbursed by an all-inclusive encounter rate, FQHC providers will not receive the case management fee paid to Patient 1st providers nor the capitation fee for lock in recipients.

Costs Reimbursed by Other Than FQHC Encounter Rate

Costs reimbursed by other Medicaid programs are not reimbursed in the FQHC Program. Examples of such reimbursements include, but are not limited to:

- Maternity care, primary contractor
- Prescription drugs by enrolled pharmacy providers
- Surgical procedures performed in place of service 21 (inpatient) or 22 (outpatient) will be reimbursed fee-for-service

NOTE:

For Non-Plan First patients, the dispensing fee for birth control pills is a non-covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Plan First recipients who choose to use oral contraceptives (OCPs), the contraceptive patch or vaginal ring and are seeing providers at a Federally Qualified Health Center (FQHC) will have the option of obtaining these supplies from the FQHC or a Medicaid enrolled community/outpatient pharmacy. In order to fill a prescription at a community/outpatient pharmacy, the Plan First-eligible patient must have received the prescription from their Plan First provider. A 30 day supply is the maximum that may be dispensed at one time.

FQHC's will provide and bill for oral contraceptives, the contraceptive patch and the vaginal ring using their NPI. Covered services using this NPI are limited to the following procedure codes with modifier:

- S4993 SE Oral Contraceptives
- J7304 SE Contraceptive Patch
- J7303 SE Contraceptive Ring

These services are limited to 13 units annually and **should be billed for Plan First recipients only.**

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

NOTE:

Effective 5/1/2012, Federally Qualified Health Centers may submit claims for Mirena®, Paragard®, and Implanon® fee-for-service outside the encounter rate. FQHC and RHCs may submit a separate medical claim using the following procedure codes:

Mirena ® - J7302

Paragard ® – J7300

Implanon ® - J7307

In order for FQHC's to be eligible to bill Plan First visits, they are required to be enrolled in Plan First. The Plan First visit will be reimbursed at the encounter rate when billed.

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

1st Look- The Oral Health Risk Assessment and Dental Varnishing Program

Effective January 1, 2009 Medicaid will cover the application of fluoride varnishes for children 6 months through 35 months of age who have a moderate to high caries risk based on the risk assessment by Patient 1st medical providers and their clinical staff (RNs, PAs, Nurse Practitioners, LPNs). This assessment and varnish program is to be incorporated into the well child visit and be part of the comprehensive care in a medical home. The medical provider and staff must be trained in oral health risk assessment, anticipatory guidance and fluoride varnish application. This training includes oral health risk assessment, education on performing anticipatory guidance/counseling, demonstration of fluoride varnish application and the provision of information on recommendations for a dental home. Upon completion of the oral health risk assessment training program for pediatricians and other child health professionals, a specialty indicator will be added to the provider file in order for the provider to receive reimbursement.

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual's Dental Chapter 13.

NOTE:

Costs for Maternity Care sub-contractors are not an allowable cost and are shown only in the non-reimbursable section of the cost report.

16.2.4 Encounters

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services. A patient may have one physical health encounter and one behavioral health encounter on the same day. If the patient later suffers an illness or injury requiring additional diagnosis or treatment on the same date of service, a separate encounter may be billed.

Dental services are limited to one dental encounter per date of service. A patient can have one dental encounter in addition to one physical health and/or behavioral health encounter on the same day. **Please refer to Dental Provider Manual Chapter 13 for additional Dental guidelines.**

Encounters are classified as billable or non-billable.

Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to Medicaid's fiscal agent for payment through the proper filing of claims forms. Billable services must be designated by procedure codes from the Physicians Current Procedure Terminology (CPT) or by special procedure codes designated by Medicaid for its own use.

Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above (i.e., visits to social worker, LPN). Such services include, but are not limited to, weight check only or blood pressure check only. Non-billable encounters cannot be forwarded to Medicaid's fiscal agent for payment.

16.3 Prior Authorization and Referral Requirements

FQHC procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

16.4 Cost Sharing (Copayment)

The copayment amount is **$3.90** per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

16.5 Medicare Co-insurance

For Federally Qualified Health Centers, Medicaid pays the Medicare co-insurance up to the encounter rate established by Medicaid.

16.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

FQHC providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

NOTE:

Physicians, Certified Registered Nurse Practitioners, and Physician Assistants bill using their own NPI on Block 24J of the CMS-1500 claim form. Enter the clinic's number in Block 33 in the GRP # portion of the field. Please refer to Section 5.2.2, CMS-1500 Claim Filing Instructions, for more information.

16.6.1 Time Limit for Filing Claims

Medicaid requires all claims for FQHC providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

16.6.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

16.6.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Refer to Appendix H, Alabama Medicaid Injectable Drug Listing.

Claims without procedure codes or with codes that are invalid will be denied. Medicaid recognizes modifiers when applicable. Both CPT and CMS level codes will be recognized. The (837) Professional, Institutional and Dental electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Nurse Practitioners/Physician Assistants

Covered services for FQHC-employed nurse practitioners and physician assistants are limited to the following:

- VFC codes, as specified in Appendix A, EPSDT
- Injectable drug codes, as specified in Appendix H, Alabama Medicaid Injectable Drug List
- Laboratory codes for which the clinic is certified to perform
- CPT codes as specified in Appendix O, CRNP and PA Services

Effective January 1, 1998, services provided by Registered Nurses (RNs) employed in a FQHC will be reimbursed only under the FQHC site name and number. Reimbursable services provided by an RN in an FQHC are restricted to the following:

Procedure Codes	***Description***
99205-FP	Family Planning, initial visit
99214-FP	Family Planning, annual visit
99213-FP	Family Planning, periodic revisit
99212-FP	Family Planning, expanded counseling visit
99401	Family Planning, HIV pre-test counseling
99402	Family Planning, HIV post-test counseling
99381-EP	Initial EPSDT, Normal, under 1 year of age
99382-EP	Initial EPSDT, Normal, 1-4 years of age
99383-EP	Initial EPSDT, Normal, 5-11 years of age
99384-EP	Initial EPSDT, Normal, 12-17 years of age
99385-EP	Initial EPSDT, Normal, 18-20 years of age
99381-EP	Initial EPSDT, abnormal, under 1 year of age
99382-EP	Initial EPSDT, abnormal, 1-4 years of age
99383-EP	Initial EPSDT, abnormal, 5-11 years of age
99384-EP	Initial EPSDT, abnormal, 12-17 years of age
99385-EP	Initial EPSDT, abnormal, 18-20 years of age
99381-EP	Periodic EPSDT, normal, under 1 year of age
99382-EP	Periodic EPSDT, normal, 1-4 years of age
99383-EP	Periodic EPSDT, normal, 5-11 years of age
99384-EP	Periodic EPSDT, normal, 12-17 years of age
99385-EP	Periodic EPSDT, normal, 18-20 years of age
99381-EP	Periodic EPSDT, abnormal, under 1 year of age
99382-EP	Periodic EPSDT, abnormal, 1-4 years of age
99383-EP	Periodic EPSDT, abnormal, 5-11 years of age
99384-EP	Periodic EPSDT, abnormal, 12-17 years of age
99385-EP	Periodic EPSDT, abnormal, 18-20 years of age
*99391	Interperiodic Screening, Infant age- below 1 year old
*99392	Interperiodic Screening, Early Childhood-age 1 thru 4 years
*99393	Interperiodic Screening, Late Childhood-age 5 thru 11 years
*99394	Interperiodic Screening, Adolescent-age 12 thru 17 years

Procedure Codes	*Description*
*99395	Interperiodic Screening-age 18 thru 20 years
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen

* Must be approved by the Alabama Medicaid Agency to provide these services.

Vaccines For Children (VFC)

The Department of Public Health provides vaccines at no charge to Medicaid providers enrolled in the Vaccines For Children (VFC) Program as recommended by the Advisory Committee on Immunization.

Medicaid reimburses administration fees for vaccines provided free of charge through the VFC Program. The rate for the administration fee is $8.00; it is not the rate on the pricing file.

Refer to Appendix A, EPSDT, for procedure codes for VFC.

16.6.4 Place of Service Codes

The following place of service codes apply when filing claims for FQHC services:

POS	*Description*
11	Office
12	Home
15	Mobile Dental Clinic
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
54	Intermediate Care/Facility/Mentally Retarded

NOTE:

Outpatient surgery, outpatient hospital visits, and nursing facility visits should be billed using the FQHC number for the physician rendering services. Do not bill these services on the same claim as other FQHC services.

16.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

16.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Alabama Medicaid Injectable Drug List	Appendix H
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N