

	<p>Federally Qualified Health Centers</p> <p>Provider Specific Policy</p> <p>Revision Table</p>
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Revision Date	Sections Revised	Description
12/2/05	All Sections	FQHC policy removed from Practitioner Provider Specific Policy Manual. FQHC Provider Specific Policy Manual created. Content remained unchanged.
06/12/08	2.2 and 3.1	2.2 Adjusted the CFR citation. Expanded upon “medical encounter” definition as per CFR.
06/15/2016	2.5	Updated section to include clarifications regarding fluoride varnish.
07/01/2016	2.0	Updated manual to include dental services.
07/01/2016	3.1	Added billing guidance for dental services.
08/01/2017	All	Updated language in compliance with the Delaware Medicaid Enterprise System (DMES) change from “client” to “member”
08/01/2017	2.5	Added Long Acting Reversible Contraception (LARC) and Chronic Care Management Services
08/01/2017	3.1.3	Added HCPCS “G” visit billing codes effective for dates of services on or after 09/01/2017.
10/01/2017	3.1.3	Clarification added regarding the appropriate billing of Long Acting Reversible Contraception devices.
8/01/2018	3.1.3	Updated policy for the billing of Long Acting Reversible Contraception (LARC) devices and related procedures, effective 1/1/2018.
8/01/2018	4.1.4	Effective July 1, 2018, payment methodology reimbursement updated to align with State Plan.
05/20/2021	2.5	Updated policy to align with the State Plan and United States Preventive Services Task Force (USPSTF) recommendations for Obesity Treatment and Intervention.
10/01/2021	2.3	Updated behavioral health services policy to include Licensed Professional Counselors of Mental Health (LPCMHs) and Licensed Marriage and Family Therapist (LMFTs) as additional provider types.

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Federally Qualified Health Centers Provider Specific Policy

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Federally Qualified Health Centers Provider Specific Policy

Federally Qualified Health Centers (FQHCs) services are provided to the majority of Medicaid members through a Managed Care Organization (MCO). FQHC services are included in the MCO benefits package. All Medicaid members who are enrolled with an MCO must receive FQHC services through the MCO.

This manual reflects the policies as they relate to Medicaid members who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy).

1.0 General Information

1.1 Federally Qualified Health Centers (FQHC)

1.1.1 The FQHC must:

1.1.1.1 Be licensed by the state agency responsible for licensing and certification.

1.1.1.2 Be enrolled with a valid contract with the Delaware Medical Assistance Program (DMAP).

1.1.2 Services provided at the center by a physician, nurse practitioner, physician assistant, nurse midwife, clinical psychologist and clinical social worker are payable only to FQHC. The services furnished must be within the scope of licensure of the physician, nurse practitioner, physician assistant, nurse midwife, clinical psychologist and clinical social worker.

1.1.3 Visits to a hospital (including emergency room) or other inpatient services provided by FQHC practitioners are not considered a reimbursable FQHC encounter and are not payable to the FQHC. Inpatient services are payable only to individually enrolled physicians or physician groups.

1.1.4 A visit is a face-to-face encounter between a center patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

1.1.5 FQHC services must be provided in an outpatient setting.

2.0 Services

FQHC services include: physician nurse practitioner; physician assistant nurse midwife service; clinical psychologist and clinical social worker services; supplies incident to services; preventive services; and dental services

2.1 Physician Services

- 2.1.1 Physician services are professional services performed at the center by a physician that are within the scope of his/her licensure. Professional services by a physician for a patient may include diagnosis, therapy, surgery and consultation.
- 2.1.2 Telephone Services- services by means of a telephone call between a physician and a patient (including those in which the physician provides advice or instructions to or on behalf of the patient) are covered services that are included in the payment made to the FQHC and should not be billed as an encounter.
- 2.1.3 Prescription Services- Visits for the sole purpose of obtaining or renewing a prescription, the need for which was previously determined (so that no examination of the patient is performed), are not covered services and should not be billed as an encounter.

2.2 Nurse Practitioner/Physician Assistant/Nurse Midwife Services

- 2.2.1 Professional nurse practitioner, physician assistant, nurse midwife services are reimbursable if:
 - 2.2.1.1 Furnished by a nurse practitioner, physician assistant, nurse midwife who is employed by, or receives compensation from, the FQHCs;
 - 2.2.1.2 Furnished under the medical supervision of a physician;
 - 2.2.1.3 Furnished in accordance with any medical orders for the care and treatment of a patient prepared by a physician;
 - 2.2.1.4 The service provided would be covered if furnished by a physician.
- 2.2.2 The physician supervision requirements is met if the conditions specified in the 42 CFR §491.8 (b) are satisfied.

2.3 Behavioral Health Services

- 2.3.1 For behavioral health services to be payable, the service must be:

- 2.3.1.1 Furnished by an individual who owns, is employed by, or furnishes services under contract to the FQHC.
- 2.3.1.2 Of a type of licensed behavioral health service provider that is legally permitted to perform by the State in which the service is furnished.
- 2.3.1.3 Covered if furnished by a physician.
- 2.3.1.4 Covered when furnished by the following provider types that are currently enrolled in DMAP and associated with the FQHC:
- Licensed Psychologists
 - Licensed Clinical Social Workers (LCSWs)
 - Licensed Professional Counselors of Mental Health (LPCMHe)s)
 - Licensed Marriage and Family Therapists (LMFTs)
- 2.3.2 The physician supervision requirement is met if the conditions specified in 42 CFR §491.8 (b) are satisfied.

2.4 Services and Supplies Incident to Services

- 2.4.1 Services and supplies incident to physician, nurse practitioner, physician assistant, nurse midwife, clinical psychologist and clinical social worker services are reimbursable if the service or supply is:
- 2.4.1.1 Of a type commonly furnished in a physician's office;
- 2.4.1.2 Of a type commonly rendered either without charge or included in the FQHC's bill;
- 2.4.1.3 Furnished as an incidental, although integral, part of the professional service;
- 2.4.1.4 Furnished under the direct, personal supervision of a physician, nurse practitioner, physician assistant, nurse midwife, clinical psychologist and clinical social worker; and
- 2.4.1.5 In the case of a service, furnished by a member of the center's health care staff who is an employee of the center.
- 2.4.2 Only drugs and biologicals which cannot be self administered are included within the scope of this benefit.

2.5 Preventive Primary Care Services

- 2.5.1 Preventive primary care services are those health services that:

- 2.5.1.1 Are furnished by or under the direct supervision of a physician, nurse practitioner, physician assistant, nurse midwife, clinical psychologist, or clinical social worker;
- 2.5.1.2 Are furnished by a member of the center's health care staff who is an employee of the center or by a physician under arrangements with the center; and
- 2.5.1.3 Except as specifically provided in section 1861(s) of the Act, include only drugs and biologicals that cannot be self administered.
- 2.5.2 Preventive primary services which may be paid for when provided by FQHCs are the following:
 - 2.5.2.1 Medical social services
 - 2.5.2.2 Nutritional assessment, counseling and referral
 - 2.5.2.3 Preventive health education
 - 2.5.2.4 Children's eye and ear examinations
 - 2.5.2.5 Prenatal and post-partum care
 - 2.5.2.6 Perinatal services
 - 2.5.2.7 Well child care, including periodic screening, fluoride varnish and oral health risk assessment.
 - 2.5.2.8 Immunizations, including tetanus-diphtheria booster and influenza vaccine
 - 2.5.2.9 Voluntary family planning services
 - 2.5.2.10 Taking patient history
 - 2.5.2.11 Blood pressure measurement
 - 2.5.2.12 Weight
 - 2.5.2.13 Physical examination targeted to risk
 - 2.5.2.14 Visual acuity screening
 - 2.5.2.15 Hearing screening

- 2.5.2.16 Cholesterol screening
- 2.5.2.17 Stool testing for occult blood
- 2.5.2.18 Dipstick urinalysis
- 2.5.2.19 Risk assessment and initial counseling regarding risks
- 2.5.2.20 Tuberculosis testing for high risk patients
- 2.5.2.21 For women only - clinical breast exam, referral for mammography, and thyroid function test.
- 2.5.2.22 For women only - Long Acting Reversible Contraception (LARC) services. These services are reimbursed separately and are billed alone or with other payable services on a FQHC claim. When reporting this service as a standalone billable visit, a FQHC payment code is not required.
- 2.5.2.23 Chronic Care Management. This service is reimbursed separately and is billed alone or with other payable services on a FQHC claim. When reporting this service as a standalone billable visit, a FQHC payment code is not required.
- 2.5.3 Preventive primary services do not include group or mass information programs, health education classes, or group education activities, including media productions and publications.
- 2.5.4 Screening mammography is not considered a FQHC service, but may be provided at a FQHC if the center meets the requirements applicable to that service specified in 42 CFR §410.34
- 2.5.5 Preventive primary services do not include eyeglasses, hearing aids, or dental services with the exception of fluoride varnish.

2.6 Dental Services

- 2.6.1 Must be furnished by or under the direct supervision of a Medicaid enrolled Dentist and comply with the rules and regulations of the Board of Dentistry and Dental Hygiene.
- 2.6.2 Refer to the Dental Provider Specific Policy Manual for covered dental services, frequency limitations, prior authorization, and guidance.

3.0 Billing Information

3.1 Specific Billing Instructions

- 3.1.1 Medical FQHC services shall be billed per “medical encounter”. “Encounter” is defined as a face to face visit between a FQHC patient and any health professional whose services are reimbursed under the State Plan for the purpose of diagnosis or treatment. Claims are limited to one all-inclusive “encounter” per day, to include **all** services received by an eligible recipient on a single day or relevant to the “encounter”. All subsequent services and follow-up care provided by other than a physician, nurse practitioner, or physician’s assistant, ordered as a result of an “encounter” are included in the related “encounter” rate, and are not billed separately.
- 3.1.1.1 Exception is made for cases in which the patient, subsequent to the first “encounter” suffers illness or injury requiring additional diagnosis or treatment on the same day (42 CFR§405.2463).
- 3.1.1.2 Exception is also made if the patient has a medical visit and another health visit for mental health services on the same day (42 CFR§405.2463(a)(3)(ii)).”
- 3.1.2 A practitioner may bill the DMAP for admitting and attending an eligible Medicaid recipient in an inpatient setting if (s)he is enrolled with the DMAP as an individual/group provider. These services cannot be billed using the provider number assigned to the FQHC.
- 3.1.3 The FQHC must bill the DMAP using an FQHC HCPCS (Healthcare Common Procedure Coding System) “G” visit payment code for each payable encounter visit, along with a HCPCS code for each service provided. These codes are accepted for dates of service on or after 09/01/2017. Claims must be submitted with the correct Place of Service (POS).
- 3.1.3.1 **DMAP FFS Members**
FQHC providers must bill the contraceptive device, insertion and removal of the contraceptive device to DMAP for DMAP members that are FFS only. Use the diagnosis codes that are appropriate for the device and related procedures.
- 3.1.3.2 **MCO Members**
FQHC providers must bill the contraceptive device and related services to the MCO. The FQHC should refer to the members corresponding MCO’s billing instructions for claims submission guidance.
- 3.1.4 Dental FQHC services must be billed on an ADA claim form using CDT codes. Dental services must be billed at the (UCR) Usual, Customary and Reasonable

will be reimbursed in accordance with the Dental Provider Specific Policy Manual.

- 3.1.5 FQHC dental claims must list the billing provider as the General Dentist and include the rendering providers NPI and Taxonomy with service location 50. Claims not submitted with this enrollment will be denied reimbursement.

4.0 Reimbursement

4.1 Methodology

- 4.1.1 FQHCs are required to submit a Medicaid Cost Report annually, due within 90 days after the provider's fiscal year end.
- 4.1.2 The rate year for FQHC services is July 1 through June 30.
- 4.1.3 The payment methodology for FQHCs will conform to the BIPA 2000 Requirements Prospective Payment System (PPS).
- 4.1.4 The Centers for Medicare and Medicaid Services (CMS) requires that FQHCs be reimbursed in compliance with section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. Effective July 1, 2018, Delaware will reimburse each FQHC per-visit through one of the following two (2) methodologies, whichever nets the greater result:
1. A prospective payment system (PPS) rate, where 100 percent of the reasonable costs based upon an average of their fiscal years 1999 and 2000 audited cost reports are inflated annually by the Medicare Economic Index (MEI); or
 2. The per-visit cost as reported by the FQHC in its most recent cost report, subject to an audit performed by a certified public accountant as to the reasonableness of the reported costs.
- 4.1.5 FQHCs are assigned a prospectively determined rate per encounter based on actual reported costs.
- 4.1.6 Primary Care costs and Administrative and General costs are each reviewed individually for purposes of rate calculation. The Administrative and General component is capped at 40% of the total cost. Each cost component is inflated by the current CMS Medicare Economic Index (MEI).
- 4.1.7 Criteria for Adjusting PPS Rates Due to Change in Scope of Services
- 4.1.7.1 A change in the scope of service shall occur if the FQHC has added or discontinued any service that meets the definition of FQHC services as provided in Section 1905(a) (2) (B) and (C) of the Act, **and** the service is included as a covered Medicaid service under the DMAP State Plan **or** is required by Federal regulations to be covered by Delaware Medicaid. A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of services compared to the services offered at the time of the last change of scope rate adjustment. A change in the cost of service alone is not considered a

change in the scope of service. Significant increases or decreases to the magnitude, intensity or character of service offered by the FQHC attributable to changes in the types of patients served shall qualify, such as services to patients with HIV/AIDS or other chronic disease, or the homeless, elderly, migrants, or other special populations. Examples that are considered a change in the scope of service for which DMAP shall adjust the PPS rate if all qualifying requirements are met include (but are not limited to):

- 4.1.7.1.1 A change in the volume or amount of services as a result of a significant expansion or reduction of an existing clinic, or the addition or discontinuation of a satellite or new site.
- 4.1.7.1.2 A change in operational costs that is attributable to capital expenditures, including new service facilities or regulatory compliance, providing that the additional costs result in a change to the volume, amount, or intensity of services. The cost of a new or expanded building alone would not necessarily qualify.
- 4.1.7.1.3 The addition or deletion of any Medicaid covered service eligible under the FQHC reimbursement program.
- 4.1.7.1.4 A change in operational costs attributable to changes in technology or medical practices at the FQHC.
- 4.1.7.1.5 A change of costs due to recurring taxes, malpractice insurance premiums, or workman's compensation insurance premiums that were not recognized and included in the base year calculation.
- 4.1.7.1.6 A change in Federal regulatory requirements that would impact FQHC costs.
- 4.1.7.1.7 A Health Resources and Services Administration (HRSA), Bureau of Primary Health Care approved change of site or scope of service, providing the change is consistent with Federal and State Medicaid regulations.
- 4.1.7.2 Qualifying requirements for PPS adjustments due to change in scope of service include:
 - 4.1.7.2.1 The net effect of all qualifying changes in scope of service must demonstrate to DMAP the likelihood of at least a 2.5% annual difference in Medicaid allowable costs compared to the costs used to compute the last approved PPS rate. If a 2.5% or more cost differential occurs between consecutive years, the DMAP shall adjust the PPS rate.
 - 4.1.7.2.2 A minimum of three (3) months operational and cost experience must be demonstrated within the cost reporting year to establish that the change was not temporary.

- 4.1.8 A change in scope of services cost adjustment may be initiated by DMAP or requested by the FQHC.
- 4.1.8.1 If a change in scope adjustment is requested by the FQHC or DMAP, the FQHC will identify all known cost increases or decreases associated with all changes in scope on separate cost forms approved by DMAP. The change in scope cost forms must be submitted no later than the annual Medicaid Cost Report. The FQHC will submit to DMAP reasonable documentation to support changes in scope cost increases or decreases. The FQHC shall notify DMAP in writing at least 60 days in advance of the effective date of any anticipated or planned changes in scope (or at the time a change occurs if unplanned), and the reason for the change, in order for the State to consider budget requirements.
- 4.1.8.2 The DMAP will review change in scope of service cost reports and determine if changes reflected in the change of scope cost reports qualify for a rate adjustment, based on the criteria in Section 4.1.7. The DMAP will determine a reasonable definition for supporting documentation necessary to determine if the scope of services has changed and at what change in cost.
- 4.1.8.3 If DMAP determines that a change in the scope of service has occurred, based on the qualifying requirements outlined above, the reasonable annualized incremental or decremental costs will be computed on a per visit (encounter) basis to determine a change in scope encounter rate. The PPS rate for the current year will be inflated using the MEI to determine the base PPS rate for the upcoming year. The change in scope encounter rate will be added to (or subtracted from) the base PPS rate for the upcoming year to determine a final PPS rate for the upcoming year.

NOTE: An encounter is a unit of service for which the FQHC PPS rate is computed. At the beginning of each new rate year, DMAP will consider a request to change the definition of encounter. However, any change in definition (not related to a change in scope or change in costs) that would increase the number of billable encounters will require DMAP to compute a lower PPS rate. Conversely, any change in definition that would decrease the number of billable encounters will require DMAP to compute a higher PPS rate.