Federally Qualified Health Center

Reimbursement Policy ID: RPC.0015.2400

Recent review date: 05/2024

Next review date: 03/2025

Select Health of South Carolina reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Select Health of South Carolina may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy addresses covered services provided by Federally Qualified Health Centers (FQHCs) and how these services are reimbursed. Federally Qualified Health Centers are paid based on the FQHC Wrap Methodology for medically necessary primary health services and qualified preventive health services provided by a FQHC health provider.

Exceptions

N/A

Reimbursement Guidelines

The wrap payment methodology became effective on October 1, 2023. Billing requirements are below.

Allowed CPT Codes (1) (9)	**Exclusions from FQHC Encounter Rate (3) (8)**
Billable as a Medical Encounter:	59025 (TC Modifier)
T1015	**Imaging/Radiology**

99202-99205	(70000-79999 TC portion only)
99212-99215	Series – 70 percent removed for Tech component (4)
99242-99245	99250/TC; 93325/TC; 93880/TC; 93970/TC
99381-99385	**Covid Testing**
99391-99395	0202U, 86328, 86769, 87426, 87428, 87635-87637, 87811, (U0001-U0002)
Add. Codes for Bi-annual Exams - Adult	**Immunization Coding/Immunization (10)**
99386, 99387, 99396, 99397	90375-90756
Podiatry	Q2035-Q2039
Standard E&M Codes - see above	**Covid Vaccine and Administration (11)**
Ophthalmology	**Allowed CPT Codes (1) (9)**
92002, 92004, 92012, 90214	**Vision Services**
Chiropractic	92340
98940-98942	**Electrocardiography**
In-Home, Domiciliary or Rest Home Services	93005, 93017, 93041, 99225, 99217-99999*
99341-99345; 99347-99350	**Long Lasting Reversible Contraceptives**
Skilled Nursing Facility Services	A4261, A4264, A4266-A4269, J1050, J7296-J7298
99304-99301; 99315-99316	J7300, J7301, J7307
Family Planning Services (separate visit)	**Drug Testing**
99401-99402	80305, 80307, G0480
Post-Partum Care	**Substances Abuse Services**
59430	Q9991-Q9992, J2315
Health Risk Assessment (Foster Care)	**Telehealth Originating Site**
96160, 96161	Q3014
MNT/Nutritional Counseling; Obesity Initiative	**After Hours Services**
97802, 97803	99050, 99051
Billable as a Behavioral Health Encounter	**PHE Limited Telehealth Coding**
90791, 90792, 90832-90834, 90836-90839, 90847	G2010, G2012, (99441-99443), (98966-98968), 92507
96130, 96136, T1015/HE	97110, 97350, (99381-99385), (99391-99395)

*Any Hospital Based Service code in this range unless included in the “Allowed CPT Code” column.
(1) Allowed CPT Codes are those services considered as an eligible FQHC encounter service. They are includable in the WRAP “count”.
(2) Behavioral Health Services codes that are considered as an eligible FQHC encounter. A behavioral health code can be provided and billed on the same date of service as a medical service. Both services/encounters will be included in the WRAP settlement.
(3) Excludable procedure codes billed under Select Health of South Carolina arrangements are not includable in the WRAP payment calculations and thus are carved out and reimbursed separately outside of the FQHC encounter rate. For any procedure code billed outside of those identified under sections (1), (2), (3), payment of these codes is included in the FQHC encounter service rate and thus should not be separately reimbursed.

(4) The professional component of the 70000 series procedure codes is included in the FQHC encounter service rate and thus should not be separately reimbursed.
(5) Current policy allows dietitian services as incident to a physician or mid-level service. That is the beneficiary is seen by the provider (physician or mid-level) and dietician on the same day, one encounter can be billed for the services provided on that day. Dietician services can not be billed independently of the services provided by the physician or midlevel.
(6) Group services should never be billed using the encounter rate. A billable encounter is a face-to-face, one-on-one service with a physician or mid-level practitioner.
(7) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or excludable services.
(8) Note time limited/temporary telehealth coverage benefits per Medicaid Bulletins (MB) dated March 19, 2020 (MB# 20-004) March 23, 2020 (MB# 20-005) and March 25, 2020 (MB# 20-007), as additional Bill Above services. These services will be extended through May 11, 2024.
(9) Time limited/temporary telehealth coverage benefits include reimbursement of encounter visits not done via an in person visit at the enhanced primary care rate through May 11, 2024.
(10) Adult reimbursement only, VFC reimbursed for vaccines for children. Child reimbursement is limited to vaccine reimbursement only.
(11) Covid Vaccine and Vaccine Administration codes are effective as of 9/11/2023.

Definitions

Federally Qualified Health Center
FQHCs are public health centers focused on serving at-risk and underserved populations.
Minimum services required including, but not limited to, maternity and prenatal care, preventive health and dental services, emergency care, and pharmaceutical services. Other services may include vision services, auditory services, behavioral health services, physical therapy, and speech therapy.

Wrap Around Payment
Under federal Medicaid law, a MCO must pay FQHCs no less than they would pay other providers for similar services. In some states, the state makes a supplemental payment (often referred to as a “wraparound payment”) to the health center for the difference between the MCO payment and the FQHC PPS/Alternative Payment Model (APM) rate.

Edit Sources

I. Current Procedural Terminology (CPT)
II. Healthcare Common Procedure Coding System (HCPCS)
III. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and associated publications.
IV. Centers for Medicare and Medicaid Services (CMS).
V. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
VI. https://www.selecthealthofsc.com/pdf/provider/claim-filing-manual.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

05/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by Select Health of South Carolina from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section