

Federally Qualified Health Center

Reimbursement Policy ID: RPC.0015.0100

Recent review date: 02/2025

Next review date: 01/2026

Keystone First 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. Keystone First 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.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses covered services provided by Federally Qualified Health Centers (FQHC's) and how these services are reimbursed.

Exceptions

N/A

Reimbursement Guidelines

Federally Qualified Health Centers are paid under a prospective payment system (PPS) rather than billed charges for qualifying visits (i.e. encounters).

An "encounter" is defined as face-to-face contact between a patient and provider of services except for transportation services. An encounter may take place in the FQHC setting or at any other approved location. Examples of other settings include, but are not limited to, the beneficiary's place of residence (home, nursing facility, residential treatment facility) mobile vans, shelters, and hospitals.

Medical Service Encounter: An encounter between a physical health practitioner and a member during which medical physical or select behavioral services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Physical health services are those medically necessary services related to the treatment of bodily functions.

A medical physical health encounter is a face-to-face encounter as identified in the Pennsylvania State Plan, between a beneficiary and a:

- Physician
- Podiatrist
- Audiologist
- Chiropractor
- Pharmacist
- Licensed Non-Physician Practitioner, to include a
 - Certified Registered Nurse Practitioner,
 - Registered Nurse Practitioner,
 - Certified Nurse-Midwife,
 - Physician Assistant, and
 - Licensed Clinical Social Worker for case management
- Speech-language pathologist, physical therapist, occupational therapist
- Licensed Dietitian/Nutritionist for a beneficiary under 21 years of age.

Vision Encounter

Ophthalmologists and optometrists must be certified and credentialed to provide members with medically necessary services provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury of the beneficiary's vision and eye health. To be eligible for a vision encounter providers must submit a request to provide vision services to the state.

Telehealth

Telehealth is an encounter between a provider and a beneficiary in which physical health services are provided using approved electronic communication and information technologies to provide medical services at a distance. Telemedicine encounters must be provided according to the same standard of care as if delivered in-person. For reimbursement purposes the claim must include the code T1015 on the first line and additional CPT codes for any services provided. The place of service billed depends on the location the patient receives the services, patient's home (10) or provider's office (02).

Encounter for Long-Acting Reversible Contraceptive (LARC)

An alternative payment methodology (APM) at the MA Program Fee Schedule rate is available to offset the high cost of LARC devices by providing a payment in addition to the PPS payment. This includes the device and insertion or the removal of the LARC device.

Encounters and any services provided are billed on separate claim lines with appropriate modifiers. Multiple encounters with one health professional or encounters with multiple health professionals constitute a single

visit if all the following conditions are satisfied: all encounters take place on the same day; all contact involves a single PPS service; and the service rendered is for a single purpose, illness, injury, condition, or complaint. Multiple encounters on the same day constitute separate encounters if the services include dental, ophthalmology, vision or medical.

Services that are not billable as encounters include phlebotomy, specimen collections, laboratory tests, taking x-rays, visits solely for obtaining immunizations (except for the administration of the COVID-19 vaccines), allergy or other injections; filling/dispensing prescriptions/medication pick-ups of physician dispensed medications and application of topical fluoride varnish.

FQHCs are to prepare and submit claims for encounters in accordance with the Department's billing instructions outlined in the PROMISE™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form. Per CMS Medicaid FQHC guidelines, for accurate reimbursement, the encounter is billed using CPT code, T1015, with the appropriate rate on the first detail line. Providers are required to list all the CPT/HCPCS services provided during the encounter priced at zero dollars on subsequent lines. CPT codes included with the T1015 encounter code must accurately indicate the service(s) provided during the encounter and conform to National Correct Coding Initiative (NCCI) standards. Claims submitted without the corresponding CPT/HCPCS codes will be denied.

Definitions

Federally Qualified Health Center (FQHC)

Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. An FQHC is a community-based organization that provides comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse.

Prospective payment system (PPS)

FQHC PPS consisted of bundled payments that drives efficiency, not cost-based reimbursement. The PPS base rate is calculated for each FQHC, derived from the historical costs of providing comprehensive care to Medicaid patients to ensure each rate is appropriate and accurate. There is a single, bundled rate for each qualifying patient visit.

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. PROMISE Provider Handbooks and Billing Guides
- VI. Pennsylvania Outpatient Fee Schedule

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
02/2025	Reimbursement Policy Committee Approval
01/2025	Annual review No major revisions
04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First 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