2900 ~~FEDERALLY QUALIFIED HEALTH CENTERS~~INTRODUCTION

Federally Qualified Health Centers (FQHCs) are defined by the Health Resources and Services Administration (HRSA) as health centers providing comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. Nevada Medicaid reimburses for medically-necessary services provided at FQHCs and follows State and Federal laws pertaining to them. FQHCs are considered "safety net" providers that successfully increase access to care, promote quality and cost-effective care, improve patient outcomes and are uniquely positioned to spread the benefits of community-based care and patient-centered care.

FQHC clients can include individuals who are low-income, uninsured and have limited access to health care services. FQHCs provide primary care services for non-Medicaid or uninsured individuals on a sliding fee scale and provide services regardless of ability to pay. FQHCs receive Medicaid reimbursement for services they deliver to Medicaid recipients and may use grants or other sources of funding to cover costs of care provided to people who are uninsured.

2901 AUTHORITY

~~A. Medicaid is provided in accordance with the requirements of Title 42 Code of Federal Regulation (CFR) Part 440, Subpart A – Definitions, Subpart B and Sections 1861, 1929(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Social Security Act (SSA) and Section 1461 of the Omnibus Budget Reconciliation Act of 1990. Physician's services are mandated as a condition of participation in the Medicaid Program Nevada Revised Statute (NRS) 630A.220.~~

A. FQHCs were established in 1991 by Section 4161 of the Omnibus Budget Reconciliation Act (OBRA) of 1990. Medicaid coverage is provided in accordance with the requirements of Title 42 Code of Federal Regulations (CFR) Part 405, Subpart X and 42 CFR Part 491, Subpart A. FQHCs that receive or have applied for federal grant funding under Section 330 of the Public Health Services Act are monitored by HRSA for compliance under the authority of United States Code (USC) 45 USC 254b.

Physician services are mandated as a condition of participation in the Medicaid Program according to Nevada Revised Statute (NRS) 630A.220.

Section 1905(a)(2) of the Social Security Act (SSA) specifies that state Medicaid programs must cover FQHC services and any other ambulatory services offered by an FQHC and which are otherwise included in the Medicaid State Plan.

Each FQHC is responsible for maintaining its operations, including developing and implementing its own operating procedures, in compliance with all HRSA Health Center program requirements and all other federal, state and local laws and regulations (42 CFR 51c.304 (d)(3)(v)). This includes but is not limited to, those protecting public welfare, the environment and prohibiting discrimination, state facility and licensing laws and scope of practice laws.

B. The Nevada State Legislature sets forth ~~standards~~ scopes of practice for licensed professionals in the NRS for the following Specialists:

~~1. Section 330 of the Public Health Service (PHS) Act;~~

~~2.~~1. NRS Chapter 630 – Physicians and Physician Assistants and Practitioners of Respiratory Care General Provisions;

2. NRS Chapter 631 - Dentistry and Dental Hygiene;

3. NRS Chapter 632 – Nursing (including Advanced Practice Registered Nurse, Certified Nurse Midwife, Registered Nurse and Licensed Practical Nurse);

~~3.~~4. NRS Chapter 633 – Osteopathic Medicine;

~~4.~~5. NRS Chapter 635 – Podiatry;

6. NRS Chapter 636 – Optometry;

7. NRS Chapter 637 – Dispensing Opticians;

~~5.~~8. NRS Chapter 640E – Registered Dietitians;

9. NRS Chapter 641 – Psychologists;

10. NRS Chapter 641B – Social Workers;

11. NRS Chapter 652 – Medical Laboratories

~~6.~~12. NRS Chapter 450B – Emergency Medical Services;

2902 RESERVED

2903 ~~HEALTH SERVICES~~ POLICY

A. The Division of Health Care Financing and Policy (DHCFP) reimburses FQHCs an outpatient encounter rate. Nevada Medicaid reimburses for medically necessary services provided at FQHCs.

B. Encounters must include preventive and primary health services and are categorized as:

1. Medical.

2. Mental/~~b~~Behavioral ~~h~~Health.

3. Dental.

C. After February 6, 2016, FQHCs may choose to establish one Prospective Payment System (PPS) rate for each individual encounter type (medical, mental/behavioral health and/or dental.

A. FQHCs that have more than one PPS rate established may bill for each reimbursable service type once per patient/per day.

a. FQHCs that have one established PPS encounter rate, only one reimbursable encounter may be billed per day.

b. An FQHC that has two established PPS encounter rates, the FQHC may bill up to two reimbursable encounters per patient/per day.

c. An FQHC that has three established PPS encounter rates, the FQHC may bill up to three reimbursable encounters per patient/per day.

~~1.~~ D. For the purposes of reimbursement, an encounter is defined as:

1. A face-to-face "visit" or an "encounter" between a patient and one or more approved licensed Qualified Health Professional ~~or other Medicaid Qualified Provider~~ that takes place on the same day with the same patient for the same service type; this includes multiple contacts with the same provider~~.~~, except when the patient:

a. Suffers an illness or injury after the first visit that requires additional diagnosis or treatment on the same day.

b. Has a dental or mental/behavioral health visit on the same day; or

c. Has a medical encounter and a separate dental or mental/behavioral health visit on the same day.

~~2.~~B. ~~Providers~~ Licensed Qualified Health Professionals approved to furnish included in the FQHC outpatient encounter are:
services

a. Physician, Psychiatrist or Osteopath;

b. Dentist;

c. Advanced Practice Registered Nurse (APRN);

d. Physician Assistant (PA);

~~e. Certified Registered Nurse Anesthetist (CRNA);~~

~~f.~~e. Certified ~~Registered~~ Nurse Midwife (CNM);

~~g.~~f. Psychologist;

~~h.~~g. Licensed Clinical Social Worker (LCSW);

~~i.~~h. Registered Dental Hygienist (RDH);

~~j.~~i. Podiatrist;

~~k. Radiology;~~

~~l.~~j. Optometrist;

~~m.~~k. Optician;

~~n.~~l. Registered Dietitian (RD); and

~~o.~~m. Clinical Laboratory Services.

2903.1 COVERAGE AND LIMITATIONS

~~3.~~A. ~~Approved~~Medical encounter(s) ~~services include~~:

1. May be provided by Physician or Osteopath, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Certified Nurse Midwife (CNM), Podiatrist, Optometrist, Optician or Registered Dietitian (RD), under the FQHCs HRSA

approved scope of services and the practitioners applicable regulatory boards scope of practice.

2. Primary care services may include:

a. ~~m~~Medical history, physical examination, assessment of health status, treatment of a variety of conditions amendable to medical management on an ambulatory basis by an approved provider and related supplies;

~~1.~~b. Vital signs including temperature, blood pressure, pulse, oximetry and respiration;

~~2.~~c. Integral laboratory and radiology services conducted during the visits are included in the encounter as they are built into the established encounter rate and are not to be billed separately.

~~1.~~3. Early periodic screenings (Refer to Medicaid Services Manual (MSM) Chapter 1500 – Healthy Kids), for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening policy and periodicity recommendations;

~~2.4.~~ Preventive health services recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and education (Refer to MSM Chapter 600 – Physicians Services, Section 606;

5. Initial preventive physical exam should be conducted in accordance with Section 1861 (ww)(2); (exception for electrocardiograms, of the SSA and Annual Wellness Visits in Section 1861 (ddd);

~~3.~~6. Home visits;

~~4.~~7. Family ~~P~~planning services including contraceptives;

a. Up to two times a calendar year, the FQHC may bill for additional reimbursement for family planning education on the same date of service as the encounter. (See Billing Guide for more information).

~~5.~~8. For women: annual preventive gynecological examination, prenatal and post-partum care, prenatal services, clinical breast examination, thyroid function test;

~~6.~~9. Vision and hearing screening~~;~~.

B. Mental/Behavioral Health encounter(s):

1. Must be provided by contracted or employed Psychiatrist, Psychologist, APRN or LCSW who is authorized to provide mental/behavioral health services by the FQHC under the FQHCs HRSA approved scope of services and the practitioners applicable State regulatory boards scope of practice.

2. Services may include:

a. Assessments, diagnosis, treatment and/or referral. Conditions may include behavioral, mental health and/or substance use disorders including co-occurring disorders;

b. Care usually starts with a screening and may include treatment, recovery services and/or supports;

c. Treatments may include clinically appropriate evidence-based practices such as: therapy, counseling, medication management and supportive services.

C. Dental encounters: ~~office visits~~;

1. Dental encounters provided by dentists or RDH under the FQHCs HRSA approved scope of services and the practitioners applicable regulatory boards scope of practice. Encounters are to be billed as applicable with the FQHC encounter reimbursement methodology.

~~1.~~2. An FQHC may bill a dental encounter for each face-to-face encounter dental services.

3. Dentures provided by an FQHC are included in the daily encounter rate unlike the denture policy established in MSM Chapter 1000 – Dental.

a. Medicaid will pay for a maximum of one emergency denture reline and/or a maximum of six adjustments (dental encounters) done not more often than every six months, beginning six months after the date of partial/denture purchase. A prior authorization is not required for relines. The FQHCs in-office records must substantially document the medical emergency need.

b. Full ~~D~~denture~~/~~ or partial denture relines and adjustments required within the first six months are considered prepaid with the Medicaid's dental encounter payment for the prosthetic.

~~2.~~4. The FQHCs in-office records must substantially document the medical emergency need.

~~3.~~5. See MSM Chapter 1000 for all other covered and non-covered dental services.

~~7.~~D. Telehealth

1. An FQHC may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services (i.e. consult with specialist). If, for example, the originating site and distant site are two different encounter sites, the originating encounter site must bill the telehealth originating Healthcare Common Procedural Coding System (HCPCS) code and the distant encounter site may bill the encounter code.

E. "Incident To" Services

1. Approved licensed Qualified Health Professionals provide services during an encounter; "Incident To" refers to services and supplies that are integral, though incidental, part of the service. "Incident To" service(s), is not a stand-alone billable encounter for FQHCs.

   Examples of "Incident To" are, but not limited to:

   a. Commonly rendered without charge or included in FQHC bill;

   b. Commonly furnished in an outpatient clinic setting;

   c. Furnished under physician's direct supervision;

   d. Furnished by a member of FQHC staff;

   e. "Incident To" services and supplies may include but not limited to:

   e. "Incident To" services and supplies may include but not limited to:

      1. Drugs and biologicals that are not usually self-administered, (for instance: immunizations, TB testing, IV antibiotics, etc.);

      2. Bandages, gauze, oxygen and other supplies;

      3. Physical Therapy, Occupational Therapy and Speech Language Pathology;

4. Assistance by auxiliary personnel such as a nurse, medical assistant or anyone acting under supervision of physician. Except for medical students (refer to MSM Chapter 600, Section 603.1. (A). (3).).

~~2903.1~~ 2903.2NON-COVERED SERVICES

A. Non-covered services under an FQHC encounter:

1. Group Therapy;

2. Eyeglasses;

3. Hearing Aids;

4. Durable medical equipment, prosthetic, orthotics and supplies; and

5. Ambulance services.

2903.~~3~~2 ANCILLARY SERVICES

A. Ancillary services are those services which are an approved Nevada Medicaid State Plan service but are not included within an approved FQHC encounter.

1. Ancillary services may be reimbursed on the same date of service as an encounter by a licensed ~~q~~Qualified ~~h~~Health ~~p~~Professional ~~or other Medicaid qualified provider~~.

2. The FQHC must enroll within the appropriate provider type and meet all the MSM coverage guidelines for the specific ancillary service.

3. Partial Hospitalization Program (PHP) – As an extension of an FQHC's delivery model, an FQHC may have administrative oversight through a contractual agreement with an organization that provides outpatient PHP services and meets the criteria of a Certified Mental Health Clinic (CMHC). PHP services include a variety of psychiatric treatment modalities designed for recipients with chronic mental illness and/or substance abuse related disorders that require collaborative, intensive assistance normally found in an inpatient setting. Refer to MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services for PHP policy.

2903.4 FQHCs DUALLY ENROLLED AS CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC)

A. FQHCs dually enrolled as a CCBHC should determine the appropriate model to bill

medically appropriate rendered services. The FQHC and the CCBHC must have internal policies regarding the appropriate placement for treatment for their respective recipients. Medical necessity and clinical appropriateness as determined by the clinical professionals, under care coordination; are required and should be taken into consideration when services overlap both within the FQHC and/or the CCBHC scope of services. This is to determine which encounter (FQHC or CCBHC) is appropriate to request reimbursement. Care coordination is required to prevent duplicative billing for the same service occurring at the same time.

B. Services that are covered under the CCBHC model are identified on the services grid located in the CCBHC billing guide. Recipients that are accessing services that are primarily CCBHC and not an exclusively FQHC service will bill the CCBHC PPS rate. Services that are primarily FQHC specific and not exclusively CCBHC services will bill the FQHC encounter rate.

C. The Medicaid Surveillance and Utilization Review unit (SUR) will monitor in a retrospective review for any duplication of billing between the two delivery models.

2903.~~53~~ MEDICAL NECESSITY

A. To receive reimbursement, all services provided must be medically necessary as defined in MSM Chapter 100 – ~~Medical~~Medicaid Program, Section 103.1.

~~2903.4 SERVICES LIMITATIONS~~

~~A. Encounters are categorized as:~~

~~1. Medical.~~

~~2.1. Mental/behavioral health.~~

~~3.1. Dental.~~

~~B. An FQHC may be reimbursed for up to three service-specific visits per patient per day provided that the FQHC has been approved for separate established rates for each encounter type.~~

2903.~~65~~ PRIOR AUTHORIZATIONS

A. FQHC encounters do not require prior authorizations (PAs). PA requirements indicated in reference to MSM Chapters are not valid when the service is performed as an FQHC encounter. However, the patient file must contain documentation supporting medical necessity of services provided.

B. Ancillary services billed outside of an encounter must follow prior authorization policy guidelines for the specific services provided.

For billing instructions for FQHCs, please refer to the Billing ~~Manual~~ Guide for Provider Type 17, Specialty 181.

~~For Indian Health Programs (IHP) policy, please refer to MSM Chapter 3000, Indian Health.~~

2904 HEARINGS

A. Please reference Nevada Medicaid Services Manual (MSM) 3100 for hearings procedures.