MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 29, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2900 – FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2900 – Federally Qualified Health Centers (FQHCs) are being proposed to clarify policy and re-arrange the existing format to align with current MSM conventions related to structure and content. The clarification of policy includes, Federal and State authorities, further defining medical, behavioral/mental health, dental, and telehealth encounters. Revisions will also include policy for dually enrolled Certified Community Behavioral Health Centers (CCBHCs) and FQHCs, Pharmacy policy for immunizations within an FQHC pharmacy, and a clarification of prior authorization policy for FQHCs not enrolled with a Managed Care Organization.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering FQHC encounter type of services. Those provider types (PT) include but are not limited to: FQHCs (PT 17, specialty 181); CCBHCs (PT 17, specialty 188); FQHC Pharmacies enrolled under Pharmacy, (PT 28) and Managed Care Organizations (PT 62).

Financial Impact on Local Government: There is no anticipated fiscal impact known at this time.

These changes are effective June 30, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL MSM 2900 – Federally Qualified Health Centers (FQHCs)	MTL 15/18, 12/19 MSM 2900 – Federally Qualified Health Centers (FQHCs)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2900	**Federally Qualified Health Centers**	Renamed to "Introduction" to conform with MSM conventions. Added statement related to FQHCs being safety net providers.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2901.(A)	**Authority**	Corrected citation of Omnibus Budget Reconciliation Act of 1990.
2901.(B)		Moved from 2903.4: Expanded Scopes of Practices citation to include the applicable Nevada Revised Statutes (NRS) defining scopes of practice for providers who provide services within an FQHC.
2903	**Health Services**	Renamed to "Policy"; defines types of allowed encounters, payment and defines an FQHC encounter.
2903.1	**Coverage and Limitations**	New Section: defines Medical, Behavioral/Mental Health, Dental and Telehealth encounters. Provides guidance on provider types and services allowed within each FQHC encounter.
2903.3	**FQHC Pharmacies**	New Section: Provides policy related to FQHC pharmacies to administer immunizations.
2903.5	**FQHCS Dually Enrolled as A Certified Community Behavioral Health Center (CCBHC)**	New Section: Provides policy and definition of services for FQHCs that are dually enrolled as an FQHC and a CCBHC.
2903.7.(B)	**Prior Authorizations**	Provides prior authorization policy for FQHCs that are not enrolled in a Managed Care Organization.

2900 INTRODUCTION ~~FEDERALLY QUALIFIED HEALTH CENTERS~~

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. FQHCs 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.

Nevada Medicaid reimburses for medically~~--~~necessary services provided at FQHCs and follows State and Federal laws pertaining to them.

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~~ 4161 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.

B. The Nevada State Legislature sets forth scopes ~~standards~~ 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, Medical Assistants, Perfusionists and Practitioners of Respiratory Care ~~General Provisions~~;

2. NRS Chapter 631 – Dentistry, Dental Hygiene and Dental Therapy;

3. NRS Chapter 632 – Nursing;

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

5. NRS Chapter 635 – ~~Podiatry~~Podiatric Physicians and Podiatry Hygienists;

6. NRS Chapter 636 – Optometry;

7. NRS Chapter 637 – Dispensing Opticians;

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

9. NRS Chapter 641 – Psychologists;

10. NRS Chapter 641B – Social Workers;

11. NRS Chapter 652 – Medical Laboratories.

~~4. NRS Chapter 450B – Emergency Medical Services;~~

2903 ~~HEALTH SERVICES~~POLICY

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

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

1. Medical;

2. Mental/Behavioral Health; or

3. Dental.

C. FQHCs that have more than one Service Specific Prospective Payment Systems (SSPPS) rate established may bill for each reimbursable service type once per patient/per day.

1. An FQHC that has one established SSPPS encounter rate, only one reimbursable encounter may be billed per day.

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

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

4. For information about Rate Development, Prospective Payment Systems, SSPPS, Change in Scope of Services, and Supplemental Payments, please refer to the Nevada Medicaid State Plan, Attachment 4.19B.

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

~~a.~~ 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. Licensed Qualified Health Professionals approved to furnish services included in the outpatient encounter are:

~~A. Providers approved to furnish services included in the outpatient encounter are:~~

1. Physician or Osteopath;

~~a.~~2. Dentist;

~~b.~~3. Advanced Practice Registered Nurse (APRN);

~~1.~~4. Physician Assistant (PA);

~~c.~~5. Certified Registered Nurse Anesthetist (CRNA);

~~d.~~6. ~~Certified Registered~~ Nurse Midwife (NM);

~~e.~~7. Psychologist;

~~f.~~8. Licensed Clinical Social Worker (LCSW);

~~g.~~9. Registered Dental Hygienist (RDH);

~~h.~~10. Podiatrist;

~~i.~~11. Radiology;

~~j.~~12. Optometrist;

~~k.~~13. Optician;

~~l.~~14. Registered Dietitian (RD); and

~~2.~~15. Clinical Laboratory Services.

2903.1 COVERAGE AND LIMITATIONS

~~B. Approved encounter services include:~~

A. Medical Encounter(s):

1. May be provided by an employed or contracted Physician or Osteopath, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Nurse Midwife (NM), Certified Registered Nurse Anesthetist (CRNA), Podiatrist, Optometrist, Optician, or Registered Dietitian (RD) under the FQHCs HRSA approved scope of services and the practitioners applicable state regulatory board's scope of practice. Encounters are to be billed as applicable with the FQHC encounter reimbursement methodology.

2. Services may include:

   a. Primary care services 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. Vital signs including temperature, blood pressure, pulse, oximetry and respiration;

2. 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.

b. ~~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; Refer to Medicaid Services Manual (MSM) Chapter 1500 – Healthy Kids.

c. 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~~;

d. Home visits;

e. Family ~~Planning~~ planning services including contraceptives;

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~~ Refer to Billing Guide, Provider Type 17, Specialty 181 for more information~~)~~.

f. For women: annual preventive gynecological examination, ~~prenatal and post-partum care, prenatal services,~~ clinical breast examination, thyroid function test~~;~~, and maternity care services which includes antepartum, labor and delivery, and postpartum care services;

g. Vision and hearing screening;

B. Behavioral/Mental Health Encounter(s):

1. May be provided by employed or contracted Psychiatrist, Psychologist, APRN, PA, or LCSW who is authorized to provide mental/behavioral health services by the FQHC under the FQHC's HRSA approved scope of services and the practitioner's applicable state regulatory board's scope of practice.

2. Conditions may include behavioral/mental health, and/or substance use disorders including co-occurring disorders. Services may include

a. Screening, assessments, diagnosis, and/or treatment.

b. Treatments may include clinically appropriate evidence-based practices suchas therapy, counseling, and medication management.

c. Refer to MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services.

C. Dental Encounter(s):

1. Dental encounters are provided by employed or contracted Dentists or RDHs, under FQHCs HRSA approved scope of practices and the practitioner's applicable regulatory boards of practice. Encounters are to be billed as applicable with the FQHC encounter reimbursement methodology.

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

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

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

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

~~h.~~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. Refer to MSM Chapter 3400 – Telehealth Services

2903.~~1~~2 NON-COVERED SERVICES

A. Non-covered services under an FQHC encounter:

1. Group ~~Therapy~~therapy;
2. Eyeglasses;
3. Hearing ~~Aids~~aids;
4. Durable medical equipment, prosthetic, orthotics and supplies; and
5. Ambulance services.

2903.3 FQHC PHARMACIES

A. FQHC pharmacies who want to bill Medicaid for vaccines administered by pharmacists must do so through point of sale as a Provider Type 28. Refer to MSM Chapter 1200 – Prescribed Drugs

2903.~~2~~4 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 ~~qualified~~ Qualified ~~health~~ 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.

2903.5 FQHCs DUALLY ENROLLED AS A 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 ofservices. 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. Refer to the MSM Chapter 2700 – Certified Community Behavioral Health Center, and Billing Guide (Provider Type 17, Specialty 188), for guidance related to CCBHC policy and billing.

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

2903.~~3~~6 MEDICAL NECESSITY

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

~~2903.4 SERVICES LIMITATIONS~~

~~A. Encounters are categorized as:~~

~~1. Medical.~~

~~2. Mental/behavioral health.~~

~~3. 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.~~5~~7 PRIOR AUTHORIZATIONS

A. FQHC encounters do not require prior authorizations (PAs). PA requirements indicated in reference to MSM Chapters do not apply ~~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. FQHCs not contracted with a Managed care Organization (MCO), must follow the MCOs prior authorization policy.

~~B.~~C. 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, including Tribal FQHCs please refer to MSM Chapter 3000, Indian Health.