Medicaid Services Manual
Transmittal Letter

January 30, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres* Casey Angres (Feb 13, 2024 13:44 PST)
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 2900 – Federally Qualified Health Centers

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 2900 – Federally Qualified Health Centers (FQHC) are being proposed to clarify language around Mental/Behavioral Health encounters. The updated language identifies qualified providers of Mental/Behavioral Health encounter services; providers shall deliver services under the scope & practice of their licensure using appropriate diagnostic tools for behavioral health treatment. Language around mental health and substance use treatment including co-occurring treatment has been updated, in alignment with MSM Chapter 400.

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: The proposed updates affect all Medicaid-enrolled providers delivering mental health and substance use treatment including co-occurring treatment services in a FQHC setting. Those provider types (PT) include but are not limited to: Behavioral Health, Outpatient Treatment (PT 14), Psychologist (PT 26), Special Clinics (PT 17, Specialty 181), and Indian Health Programs and Tribal Clinics (PT 47).

Financial Impact on Local Government: The financial impact is unknown at this time.

These changes are effective January 31, 2024.

Material Transmitted	Material Superseded
MTL 03/24 MSM Chapter 2900 – Federally Qualified Health Centers	MTL 10/22, 11/21 MSM Chapter 2900 – Federally Qualified Health Centers

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 2901(A)	**Authority**	Added Public Health Service (PHS) Act.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 2903(D)(1)(g)	**Policy**	Clarified Licensed Psychologist.
Section 2903(D)(1)(q)		Added acronym for Licensed Marriage and Family Therapist (LMFT).
2903.1(B)	**Coverage and Limitations**	Use of consistent terminology for Mental/Behavioral Health Encounter.
2903.1(B)(1)		Use of consistent terminology for Mental/Behavioral Health Encounter. Clarified the definition of the encounter. Added clarifying language and acronyms where appropriate for qualified providers of the encounter.
2903.1(B)(2)		Clarification of independently licensed behavioral health providers billing for services. Clarification of LMFT and Licensed Clinical Social Worker (LCSW) interns eligible to deliver services under encounter; ineligibility of Licensed Clinical Professional Counselor (LCPC) interns and Psychological interns, assistants, and trainees.
2903.1(B)(3)		Clarification of conditions serviced under the encounter. Language added on provider capacity and refer of patients for necessary ancillary or consultative services. Language added on client-centered treatment delivered by appropriately licensed providers. Clarification of treatment services included under the encounter.
2903.1(B)(4)		Language clarified on documentation standards and reference to MSM Chapter 100 – Medicaid Program.
2903.2	**Non-Covered Services**	Clarification of group therapy. Addition of clarifying language regarding services rendered outside the FQHC location.
2903.6	**Medical Necessity**	Addition of "Medicaid" reimbursement.
2903.7	**Prior Authorizations**	Addition of language to follow federal and state regulations.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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FEDERALLY QUALIFIED HEALTH CENTERS

2900 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. 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), Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended (including sections 330(e), (g), (h), and (i)), and Section 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 of practice for licensed professionals in the NRS for the following Specialists:

1. NRS Chapter 449 – Medical Facilities and Other Related Entities;
2. NRS Chapter 630 – Physicians, Physician Assistants, Medical Assistants, Perfusionists and Practitioners of Respiratory Care;
3. NRS Chapter 631 – Dentistry, Dental Hygiene and Dental Therapy;
4. NRS Chapter 632 – Nursing;
5. NRS Chapter 633 – Osteopathic Medicine;
6. NRS Chapter 635 –Podiatric Physicians and Podiatry Hygienists;
7. NRS Chapter 636 – Optometry;
8. NRS Chapter 637 – Dispensing Opticians;
9. NRS Chapter 639 – Pharmacists and Pharmacy;
10. NRS Chapter 640E –Dietitians;
11. NRS Chapter 641 – Psychologists;
12. NRS Chapter 641A- Marriage and Family Therapist and Clinical Professional Counselors;
13. NRS Chapter 641B – Social Workers;
14. NRS Chapter 652 – Medical Laboratories.

2902 RESERVED

2903 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.

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

A face-to-face "visit" or an "encounter" between a patient and one or more approved licensed Qualified Health Professional and/or certified 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.

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

a. Physician or Osteopath;

b. Dentist;

c. Advanced Practice Registered Nurse (APRN);

d. Physician Assistant (PA);

e. Certified Registered Nurse Anesthetist (CRNA);

f. Nurse Midwife (NM);

g. Licensed Psychologist;

h. Licensed Clinical Social Worker (LCSW);

i. Registered Dental Hygienist (RDH);

j. Podiatrist;

k. Radiology;

l. Optometrist;

m. Optician;

n. Registered Dietitian (RD);

o. Clinical Laboratory Services;

p. Licensed Pharmacist; and

q. Licensed Marriage and Family Therapist. (LMFT)

2. Certified providers approved to furnish services included in the outpatient encounter are:

a. Community Health Workers (CHW).

b. Doulas.

2903.1 COVERAGE AND LIMITATIONS

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, Licensed Pharmacist, Community Health Worker (CHW), Doulas, or Registered Dietitian (RD) under the FQHCs HRSA approved scope ofservices 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 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;

   d. Home visits;

   e. Family 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. Refer to Billing Guide, Provider Type 17, Specialty 181 for more information.

   f. For women: annual preventive gynecological examination, 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;

   h. CHW services as defined in MSM Chapter 600 – Physician Services.

   i. Doula services as defined in MSM Chapter 600 – Physician Services.

B. Mental/Behavioral Health Encounter(s):

1. A qualified mental/behavioral health encounter includes additional health services and shall be provided by an employed or contracted independently licensed professional who is authorized to provide mental and behavioral health services, including substance use disorder treatment, under the FQHC's HRSA-approved Health Center project (as applicable) and under the provider's applicable Nevada regulatory board scope of practice. Qualified providers for mental/behavioral health encounters include:

   a. Psychiatrist (MD),

   b. Licensed Psychologist,

   c. APRN,

   d. LMFT, and

   e. LCSW.

2. Enrollment as a Qualified Mental Health Professional (QMHP) allows a QMHP to deliver services under a Behavioral Health Community Network delivery model (see MSM Chapter 400). FQHCs shall bill for services delivered by an independently licensed behavioral health provider under the provider's licensure and practice. LMFT and LCSW clinical interns may deliver mental/behavioral health encounter services under appropriate clinical supervision within the FQHC and under Nevada licensing authorities; Licensed Certified Professional Counselors (LCPC) and LCPC interns are not able to deliver mental/behavioral health encounter services. Psychological interns, assistants, and trainees are not able to deliver mental/behavioral health encounter services; they may deliver ancillary services under a supervising psychologist, in accordance with MSM Chapter 400.

3. Conditions may include mental health and/or substance, including co-occurring disorders. The provider must have the capacity to provide or to refer patients for necessary ancillary or consultative services. Treatment services shall be clinically appropriate, based on client-centered needs, delivered by the appropriately licensed provider, and may include:

   a. Screening, assessments, and diagnosis, using an appropriate tool in the field of behavioral health (i.e., CASII/ESCII, LOCUS, ASAM Criteria, etc.);

   b. Individual and Family Psychotherapy;

c. Medication Management.

d. Counseling for substance use, including co-occurring disorders.

e. Counseling specific to Medication Assisted Treatment (MAT).

4. Documentation of all mental/behavioral health service encounters shall adhere to applicable HRSA Health Center Program Compliance Manual standards and to Medical Record Documentation standards within MSM Chapter 100, Medicaid Program.

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.

b. 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 need.

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

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

2903.2 NON-COVERED SERVICES

A. Non-covered services under an FQHC encounter:

1. Group therapy (any service that is delivered in a group setting rather than an individual setting);

2. Services rendered outside the FQHC location by a non-contracted agency or independently licensed provider and billed as part of the encounter;

3. Eyeglasses;

4. Hearing aids;

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

6. 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.

2903.4 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 Health Professional.

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 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. 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.

2903.6 MEDICAL NECESSITY

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

2903.7 PRIOR AUTHORIZATIONS

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

B. FQHCs not contracted with a Managed care Organization (MCO), must follow the MCOs prior authorization policy.

C. Ancillary services billed outside of an encounter must follow prior authorization policy guidelines for the specific services provided under federal and state regulations.

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

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

2904 HEARINGS

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